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CLINICAL LECTURE.

PERI-UTERINE INFLAMMATION.

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Gentlemen:—I am fortunate in being able to bring before you this morning several cases that illustrate in a very typical manner the more common forms of peri-uterine inflammation, and which will furnish us with an opportunity for a brief sketch of some of its more salient points. This pathological condition may, for the sake of demonstration, be broadly divided into two classes, viz., acute and chronic. Most cases of peri-uterine inflammation begin acutely, and, after a time, develop into a condition which may be termed chronic, although that term is not a strictly correct one. Others begin insiduously, and are only discovered after they have existed for a period of months or years.

The pathological conditions to which I wish to direct your attention are those described in the books under the various names of peri- and para-metritis, both acute and chronic, and the various forms of salpingitis. These different conditions, as viewed from a clinical standpoint, are often associated, and the result of a fairly definite sequence. Thus, we will have an inflammation of the mucosa of the uterus, of the tube mucosa, then of its peritoneal covering, the peritoneum adjoining, together with an exudation of coagulable lymph into the adjacent cellular tissue, and into the cavity of the pelvic peritoneum. The lymph in the meshes of the cellular tissue, which is at first fluid, coagulates and may finally be entirely absorbed, leaving only a slight contraction over the area involved. The peritoneal lymph coagulates

into the firm, glue-like masses that you are all familiar with, becomes partly absorbed and partly organized into connective tissue containing many lymph spaces, and binds down by its contraction the uterus and appendages to the adjacent peritoneal surfaces. Occasionally, these cases begin as a true cellulitis with effusion into the sub-peritoneal connective tissue, which may be either absorbed, leaving finally only a contraction and thickening of the base of the broad ligament, or may go on to suppuration and the formation of pelvic abscess. Pelvic abscess also often results from the rupture of a pyo-salpinx between the layers of the broad ligament.

Sepsis is the great etiological factor in the causation of these inflammations. This sepsis may be produced either by the decomposition of blood-clots, or retained bits of the foetal envelope after abortion or labor at full term, by a catarrhal or gonorrhoeal endometritis, or by the introduction of septic material into the uterine cavity, or by instruments, or fingers, that are surgically unclean.

These are the most common causes of periuterine trouble.

Less frequently, the inflammation is tubercular, mycotic, or the sequela of one of the zymotic fevers, particularly scarlet fever.

"Catching cold" is held by many eminent authorities to be a prolific cause of peri-uterine trouble in women who have been previously healthy, but personally, I believe that this, in the absence of any previous pathological condition of the mucosa of the uterus or tubes, is a factor of very slight etiological value. It is unquestionably true that any ordinary catarrhal endometritis may extend to the tubes by direct continuity of structure, and this extension would be favored by cold and fatigue, or by any agent which might produce a temporary depression of vitality.

True cellulitis is practically always the result of a direct infection of the tissues through a wound of the cervix or vaginal

vault opening into the lymphatic spaces, and this usually occurs after delivery, more rarely after other mechanical injuries to the cervical tissues.

I will now bring before you a patient who presents a characteristic picture of acute peri-uterine inflammation following abortion; a woman who had previously had no pelvic trouble. She is twenty-four years of age; she has been married three years and has given birth to one child, a boy who is now eighteen months old, and whom she suckled for a year. After weaning him at the end of this time she menstruated regularly until six weeks ago when she missed a period. She dreaded pregnancy, but denies having done anything to bring on an abortion.

According to her statement, eight days ago, she began to suffer severe, cramp-like pains, and, at the same time, began to have a rather profuse, bloody discharge from the vagina. The cramp-like pains lasted for several days and then disappeared, after the expulsion of what she terms a "bit of flesh." The bloody discharge, however, continued, and during the last few days it has been attended with an offensive odor. Last night she felt chilly, then hot and feverish. The pains have returned and are now felt as a severe, constant ache all over the lower pelvic region; more intensely on the left side, and with occasional exacerbations of greater intensity. She also complains of severe pain on defecation or micturition and her temperature by the mouth is now 102° F.

On bi-manual examination, I find the uterus in a normal position, but enlarged, soft, tender and immovably fixed in the pelvis by a well-marked swelling on the left side, filling the space above the vaginal vault and extending back of the uterus into Douglas' pouch. On the right side there is a moderate amount of thickening about the appendages, but not so marked as that on the left, where the area of exudation is doughy, cedematous to the touch, exquisitely tender and hot. The vagina is bathed in an abundant reddish, foetid discharge. The cervical canal is dilated so as to easily admit the finger tip. While it is important to subject this woman to no unnecessary manipulation, it is absolutely requisite that we satisfy ourselves that the uterus is empty and that there is no further source of sepsis in its cavity. By reason of the dilatation of the cervical canal and the offensive odor from the vagina, I suspect the retention of some portion of the ovum, and with this dull curette I will now gently explore the entire cavity.

The patient is very plucky and keeps quiet, otherwise we should have to use chloroform. This procedure is always best done at the patient's home, when practicable.

I now remove with the curette, as you see, these little masses of decomposing placental tissue and decidua, which seem to be all that have remained in the cavity of the uterus. It is now important to complete our work by irrigating the uterine cavity thoroughly with an antiseptic solution so as to wash away any debris that may remain there, and to render the cavity, as far as possible, aseptic. For this purpose, I will employ a bichloride solution of the strength of 1-4000, injecting it through this small glass catheter. You will notice that the cervix is freely enough dilated so that there can be no obstacle to the return of the water. This is a very important matter for us to know, for if we should inject any fluid into the cavity of the uterus, we might readily force a small amount of septic material, or some of the injected solution, into the tubes, and do serious damage to the patient. In private practice, it would be a much better plan to send this patient home, give her an anæsthetic and perform this operation of curetting and washing out the uterine cavity there. It is essentially important in this operation that the strictest antiseptic precautions be enjoined and carried out by the operator, as our object is to render the uterine cavity thoroughly aseptic, and so remove the *materies morbi* which gives rise to the fever, and which has already undoubtedly extended through the tubes, giving rise to a localized peritonitis. After the uterine cavity has been thoroughly cleansed in this way, the patient should be kept in bed and no further local examinations resorted to. A gentle, warm douche of a pint or two should be used twice daily for cleansing purposes. She should be kept quiet in bed for from two to three weeks until all the acute symptoms have completely subsided and the exudation markedly diminished. As long as any fever persists, an ice-bag should be kept over the suprapubic region. When the temperature drops to normal, you will find that hot poultices will afford her the most efficient relief from pain. At a later period, strong counter-irritation over the utero-ovarian region such as a blister, will give you the very best results, both in the way of relieving the pain and promoting the absorption of the peri-uterine exudation. The bowels are to be kept open by small doses of some saline laxative. For the relief of pain, I have found the most efficient agent to be

phenacetine in fifteen grain doses, in combination with from a half to one grain of codeine. Prolonged hot douches are not well borne until after the acute stage has passed. They are then useful in relieving pain and promoting the absorption of the exudate.

Our next patient illustrates a chronic condition of this same trouble. Her history at first was similar to that of the patient who has just left us. She now complains of pain low down over the sacrum, over the ovarian region, and pains of a bearing down character. She tells us that she has not been well since her second confinement.

Many of these patients come here with no history at all of any inflammatory trouble, and it often requires very careful questioning to determine when the initial inflammatory trouble began.

On bimanual examination I find the uterus displaced downward and backward, and but very slightly movable, being fixed by the adherent appendages and by direct adhesions to adjacent peritoneal surfaces. On either side there is an indurated, somewhat indefinite thickening extending down towards Douglas's pouch, where I can feel two fixed, exquisitely tender bodies, the prolapsed and adherent ovaries, the lateral masses being the thickened, convoluted and adherent tubes. There is considerable tenderness on pressure over the vaginal roof in the neighborhood of these masses, and any attempt to move the uterus gives rise to considerable pain. The patient tells me that she suffers an excessive amount of dyspareunia. This difficulty is due to the fact that both ovaries are prolapsed, adherent and acutely intolerant of any mechanical pressure. The pain she complains of on defecation, when at all constipated, is due to the same cause, the hardened fecal masses as they pass down the rectum pressing against the adherent ovary on the left side, she also complains of a profuse, glairy and sticky vaginal discharge, and on examination with the speculum I find the os reddened and eroded. The cavity of the cervix is filled by a mass of thick, tenacious, brownish-yellow mucous, pathognomonic of a cervical endometritis.

These patients can often be greatly benefited by painting the vaginal vault with a strong solution of the tincture of iodine twice a week for months, and following this by the introduction of a tampon saturated with pure glycerine or boroglyceride. These tampons should be permitted to remain in position for twenty-four hours and then re-

moved, the patient being instructed to wear a napkin in the meantime to prevent the profuse serous flow, caused by the glycerine, from soiling their linen. After the removal of the tampon in the morning, the patient should be directed to use for at least twenty minutes, a hot water vaginal douche at a temperature of 110° F. This can be done by means of a fountain syringe or syphon apparatus. These douches are best given with the patient lying on her back, with the hips elevated and supported by a hospital bedpan.

If the patient is so situated that she cannot come to your office frequently, she is to be told to use the hot douche every morning, and afterwards, to inject through a small glass syringe into the vaginal fornix, a dram of pure glycerine, or she may be directed to use glycerine vaginal suppositories. Tincture of iodine should be painted over the skin in the ovarian regions daily, unless it produces too much soreness. If the pain be severe, a series of blisters applied over the same region will be found very effective. Such treatment as this must be persisted in for months, and in a fair majority of cases, great relief, and often symptomatic cure will be the result.

The next patient is an unmarried girl nineteen years of age, who suffered from a moderate dysmenorrhœa. She comes to-day complaining of trouble that commenced with a slight chilliness, fever, pain and tenderness over the region of the appendages, following the use of the sound by a physician who, she says, took it from his pocket to introduce it, and again returned it after simply wiping it with a dry towel. She now feels weak and miserable, though still attending to her duties as housemaid. Bi-manual examination is different in this case, because of the tense abdominal walls and the tenderness of the parts. The uterus, however, we find to be sharply anteflexed and fairly movable, though any attempt at motion gives rise to pain. Laterally, we find great tenderness and some thickening of the uterine appendages. Such a pathological condition as this is often found associated with slight septic infection from careless gynecological manipulation, and affords us, as in this case, a striking illustration of the necessity for more careful asepsis in ordinary gynecological examinations. It may be safely said that if we can be sure that the vagina, cervix, instruments and fingers are thoroughly aseptic, we will very rarely produce such a pathological condition as is present here.

The treatment of this patient is best in

bed, the icebag over the supra-pubic region, and aconite or pulsatilla internally, while there is any fever present. Under the use of these remedies, the pain will probably soon disappear and the slight thickening of the appendages clear up together. The more marked examples of this condition pass into the chronic form, as illustrated in the case of our second patient, and then require the same course of treatment.

The next patient furnishes us with the history of a but too common affection in women, and clearly illustrates the deplorable effects of gonorrhœal affection. She is a woman twenty years of age and was married eleven weeks ago. Her husband, who comes with her to the clinic to-day, acknowledges that he had a gleet discharge at the time of his marriage. The wife rapidly developed an acute, gonorrhœal vaginitis, which was treated by her physician, and about the time he thought he had brought the disease under control, the woman began to complain of a sense of pain over the lower part of her abdomen. She had a slight fever, and some chilly sensations, and on local examination a condition was found for which she was referred to this clinic for treatment.

On bi-manual examination I find that the tubes, which I happen to know were in a perfectly normal condition at the time of her marriage, are now very tender, enlarged, and, as distinctly mapped out by the finger tips, stand like little sausages on either side of the uterus. They are free from adhesions and are perfectly movable, typical examples of a pure, acute salpyugitis.

If we treat this patient by rest, blisters, etc., her pain will become less, and she will be symptomatically fairly well, but those distended tubes will be still there, and after some slight exertion, there will be a leakage from their fimbriated extremities, which will result in a return of the pain and fever, to again subside after a time. She will develop a series of such recurrent attacks, and we will then find that the tubes, which at first were movable, are becoming more and more bound down by the effused lymph, until finally there will be only a firmly fixed, shapeless, tender mass to the sides and back of the uterus. All cases do not fortunately run so serious a course, but for many this picture is not overdrawn. I have seen three such cases during the past few months, all of which followed the same course. The ordinary treatment benefits them only temporarily, but does not cure the disease, or prevent the recurrences, which, at any time, may develop into a general per-

itonitis and kill your patient. In such instances as this laparotomy is the proper therapeutic course to follow, delay is dangerous and only renders the removal of the diseased appendages more difficult from the formation of increasing adhesions. It may be safely stated that if a patient comes to you with a history of oft-recurring attacks of localized pelvic inflammation, and, on examination, you find the tubes markedly enlarged, tender, prolapsed, and more or less adherent, you are fully justified in advising their prompt removal.

Apropos of this case, I may here speak of the general laxity and indifference with which many physicians regard the presence of a slight, gleet discharge in a man who contemplates marriage. He is usually told by his physician that there is no danger of infection of his wife. He accordingly marries, and the woman who had been previously in perfect health begins to suffer from increasing pain at her menstrual periods. She gives birth to a child, and after the birth of that child, even though the strictest asepsis be maintained at its delivery, she develops an attack of acute salpingitis, and is ever afterwards sterile. Or, perhaps, she does not conceive at all, but complains of increasing peri-uterine pain until finally an examination reveals a thickened and tender tube or tubes. She has recurrent attacks of acute localized peritonitis and finally comes under the knife of the surgeon.

These cases are not in any way exaggerated instances of this condition, and they go to prove that gonorrhœal infection persists, in many cases of gleet, with at least enough virulence to render the individual a dangerous husband. For this reason no man with gleet should be allowed to marry while such a pathological condition persists.

The more acute forms of gonorrhœal vaginitis are seen in young women in whom the vagina has not been toughened by repeated coitus, astringent injections, etc. In prostitutes and older women of unclean habits, gonorrhœa may, and often does exist, without any appreciable vaginitis, the vaginal mucosa being so toughened and resistant to the action of irritants that the gonococcus can make no marked impression. These women on superficial examination, may appear to be healthy and yet, because of the presence of the gonorrhœal virus in the secretion of the cervix or endometrium, they are perfectly capable of transmitting the disease to a healthy individual. This is a clinical fact that is often over-looked, and yet is a matter of very great practical im-

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portance. In any of these forms, the disease, of course, may at any time pass up the endometrium and into the tubes.

Any of the zymotic fevers may cause tubal inflammation, though authentic cases are rare. One that I now recall was in the case of a clergyman's wife who came to me for advice. She had been married nearly a year, and, on examination, I found a thick, fleshy hymen, through which I could not pass the tip of my little finger. There was also a very marked vaginismus present. The hymen was incised under chloroform, the vaginal orifice dilated, and vaginal examination revealed a large, sausage-shaped tumor on either side of the uterus. On questioning the patient afterwards, I learned that she had had a severe attack of scarlatina when 16 years of age, and since that time had suffered from scanty, painful and irregular menstruation. She was treated for a period of 18 months in the manner I have previously described and felt very much improved as a result. She subsequently became pregnant, but about the sixth month of pregnancy developed an excessive degree of hydramnion and miscarried.

The last patient I show you to-day exhibits a pathological condition known as chronic pelvic cellulitis. Chronic pelvic cellulitis is much less frequent than was formerly supposed, and occurs after injuries of the cervix or vaginal vault during labor or abortion, or after operations involving some traumatism of these parts. It often begins with a chill, a marked rise of temperature, and severe local pains. The vaginal vault on the affected side is depressed, boggy and tender. The pelvis is filled with a mass that often extends into Douglas' pouch, and the uterus is fixed and immovable. The infiltrated tissues are at first doughy, but soon acquire a characteristic woody hardness. This exudation is usually absorbed, leaving behind only thickened, contracted bands along the base of the broad ligament, such as we find in this case, or it may break down and form a pelvic abscess.

The treatment of this condition, while acute, is similar to that of the first patient I presented to you, unless it should break (suppurate) when an incision and drainage through the vagina or abdominal wall would be necessary, as soon as the presence of pus could be detected.

In the treatment of all these cases you must not forget the importance of maintaining the general nutrition of the patient at as high a plane as possible. Any systemic dyscrasia must be looked after and cor-

rected. Good food, general tonics, fresh air, cheerful surroundings, oxygen and iron are the most useful therapeutic measures at our command. Local complicating lesions must be attended to, as, for instance, an hyperplastic endometritis, with severe metrorrhagia. Here, careful dilatation and curetting, *under strict antiseptic precautions*, will often help in a very remarkable manner in improving the patient's condition.

Another point I wish to impress upon you in this connection is: Do not submit patients who have peri-uterine trouble to frequent and unnecessary manipulations. After you have once made your diagnosis, do not examine your patient every time you treat her, but only so often as it is necessary to ascertain progress in the case. Warn these patients against violent or frequent sexual intercourse, against heavy lifting and the use of tight clothing, or corsets. Do not be too anxious to perform laparotomy, for, though it may not be so brilliant an undertaking to make use of a tedious course of treatment in these cases, it is in the long run more satisfactory to them and will reflect much more credit upon you. If the patient does not improve after a time, if she continues to suffer very severe pain or has recurrent attacks of local peritonitis, then, you can always advise the radical operation. It has been my experience that many patients who suffer pain from firmly adherent appendages, do not get the relief that you would expect from their removal. This is often due to the fact that the raw surfaces left after peeling the tubes loose from their attachments, furnish tempting opportunities for stray intestinal coils to enter into undesirable alliances; connections which are difficult to prevent and to remedy.

Some of the more important lesions taught us by the study of periuterine inflammations are; that we should always use most careful antisepsis in dealing with the female pelvic organs, that we may not cause harm instead of good.

In incomplete abortion, to remove the remnants at once.

Do not let your male patients marry while they still have an "innocent gleet."

Be patient and persistent in treating obscure tubal troubles, and, as a rule, do not be in a hurry to advise or perform laparotomy.

FOR WARTS AND CORNS.

An excellent remedy for warts and corns, is a solution of salicylic acid in flexible colloidion. A saturated solution is best.

GENU VALGUM—HYDROCELE—FRACTURED RIB—ISCHIO-RECTAL ABSCESS.

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[AT PHILADELPHIA HOSPITAL.]

Here is a little boy I wish to bring before you, and on whom I hope soon to operate. The child has knock-knees or genu valgum, and I would like to tell you what that is, and just how it is formed and what is the operative procedure to remove the deformity.

This child has a puny appearance, and on looking at its face, you get a clue to the cause of the condition. Open your mouth. He cannot open his mouth very widely, and on examining we find that there are cicatrices which prevent him from doing so. On looking at them carefully you will find that they have the typical appearance of scars resulting from mucous patches. He has inherited syphilis. He had Hutchinson's teeth, but they were removed. See these cicatrices, with a perfectly white base and a certain amount of fibrous tissue all around. You find that he has also had a form of bone trouble—osteomyelitis—common in children, especially those who have inherited either the syphilitic or tuberculous diathesis.

The child has also genu valgum. What is the pathology and how does it come to pass? You all know how bones grow. You know they grow in their continuity and in their width; that at the end of the bones is an epiphysal cartilage, which is plentifully supplied with blood, and that the cells in it are in an active state of proliferation. This cartilage exists at each end of the bone and its cells grow by a phenomenon called karyokinesis, that is a splitting up of the nuclei and cell into two. These cells accumulate on the surface of the cartilage, and that is how the bone grows in its length. In its width it grows by means of the periosteum and endosteum.

What we wish to see now, is the part which this epiphysal cartilage plays in producing genu valgum. In a person who is perfectly healthy, whose cells develop uniformly and equally, the cells grow evenly to the right as the left, forward as backward; hence, as a result, the limit remains straight. If, on the contrary, the patient suffer from some diathesis, some impurity of the blood, or some disease of the cells, (which originally

may have been very few,) it is possible and it does occur that some cells are not healthy, and not able to develop new ones as they ought to be. Here on the underside they develop as they should, but, to the outer side, they do not develop so regularly; less of them are produced in a given length of time than are produced on the inner side and, as a result, there will be an accumulation of cells here and a thin layer outside, just as if a wedge were put between the bone and epiphysal cartilage, pushing the limb out. When we have the condition known as bow legs, it is the opposite to that which has taken place, and instead of thickening taking place to the inner side, it is outside. Therefore remember that this is a fault of nutrition, of development of the epiphysal cartilage and, as a result, this deformity takes place. The treatment is entirely an orthopaedic one; the surgeon directs his attention to remedy the deformity. He ought to bear in mind the diathesis which predisposes the affection. In this case we recognize the syphilitic diathesis and we ought to proceed cautiously, and give the child the benefit of all that we know. Bearing this in mind we proceed to the remedial measure, which consists simply in making the limb straight, if possible. There is only one way to do this, and that is by breaking the femur above the condyles, treating the case subsequently as a fracture of the lower third of the femur. How are we going to reach this end? We know how fractures are produced by a fall, by an extra amount of force on a particular spot. Therefore, instruments have been devised whereby the limb is held fast while the end of it lifted up, thus producing fracture. This operation is osteoclasis, the instrument the osteoclast. That operation was in vogue before the triumph of antiseptic surgery, for by it the surgeon had no external wound, but such great force has to be applied in order to obtain the result, that the tissues necessarily were much contused and the nerve vessels run great risk of being injured, so that this operation is gradually sinking into disuse, owing to the gradual advance of antiseptic means of operating. The operation now resorted to is simply to cut upon the bone, denude it of its periosteum, and, using chisel and hammer, remove a wedge-shaped piece of bone, or cut partly through, and, with a slight effort, break it. You have practically obtained the same result as you would have obtained from the osteoclast, without the bruising of the tissues. Then close the wound with a dressing that excludes the atmosphere; use Plaster of Paris dressing

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or ordinary fracture splint, and in a month or two the limb is healed and straight. Finally, the patient, especially if both limbs are operated upon, is taller than before the operation, because a straight line is the shortest distance between two points. The modern treatment, therefore, is osteotomy; the case being transformed into an aseptic compound fracture—which to-day seldom implies more risk in prognosis than a simple fracture.

HYDROCELE.

No case in surgery, however insignificant, is devoid of points from which a great deal of knowledge may be gathered. If we only knew everything about the very simplest case, we would be much further advanced than we now are. You know how to diagnose a case, and think it apparently simple, but push your research to the bottom facts and you will certainly be puzzled.

So here is a case of hydrocele in a very healthy man, a sailor. A bag fell upon him, causing a traumatism over the testicle and, as a result, there is a swelling. A swelling in that region can be one of only two conditions, either an inflammation of the gland from direct injury, called orchitis, or an inflammation of the serous membrane covering the gland, causing an effusion of serum within that closed sac which was originally a portion of the peritoneum called the tunica vaginalis. The serum gathering within this sack, forms a tumor (hydrocele) over the testicle, not a tumor of the testicle itself.

Now let us see exactly the anatomy of the parts. The spermatic cord running up with its vein and artery; the peritoneum coming down and being reflected over the surface of the testicle exactly as the serous membrane is reflected over the ribs and the lung; above the testicle the layers becoming adherent and forming a single layer from the top of the testicle up to the internal abdominal ring, over the testicle a capacity for containing water. The meaning is conveyed to you by the idea of an empty leather bag. So here it is closed, but with a capacity for holding fluid. If inflammation be excited about the sac, it will cause fluid to be poured into its cavity, which we then call a hydrocele. When this fluid is limited to the cavity extending from the bottom to the top of the testicle we simply call it a hydrocele, a fluid tumor in the tunica vaginalis testis. But there are cases where the adhesions between the inner and outer layers of peritoneum over the cord are destroyed and exu-

dation of serum between them causes a tumor extending to the top of the cord, near the external inguinal ring. In these cases we have a tumor, as we see in the man before us, extending from the bottom of the testicle to the external ring—a hydrocele of the cord.

The most frequent cause of hydroceles, both of the testis and cord, is a chronic inflammation directly or indirectly coming from old gonorrhoea. Remember that in this case, as in every other case of irritation of any part of the body, the primary agent is an irritant which causes congestion of the blood vessels, just as when you put a blister on the surface of the skin and cause the serum to come out on the surface and form a bleb; so here, on irritation, the serum comes out and forms a tumor. The irritation need not necessarily be gonorrhoeal, but may be a traumatism, which produces nearly the same thing; it produces a blister such as you get from using the oar. So, also, a traumatism to the tunica vaginalis testes will produce a similar blister.

How do I diagnose a hydrocele of the tunica vaginalis testes and how do I distinguish it from a hydrocele of the cord?

According to our theory as to the respective locations of hydroceles of the tunic of the testes and cord, if this involved only the space between the upper and lower borders of the testicle we would have hydrocele of the tunica vaginalis testes only, but as the tumor extends to the external ring, we have hydrocele of the cord also.

Again, on making gentle pressure above between the finger and thumb of one hand, and placing the other hand on the lower part of the tumor, the impulse or sensation of fluctuation is distinctly felt below, showing the presence of fluid and showing also that the cavities communicate.

The diagnosis having been made, we will wash the surface of the testicle and puncture the hydrocele.

Remember that any discharge which we may have in surgery derives its color from the blood; therefore, in traumatic hydrocele the color of the fluid is deeper, the more recent the traumatism. If this hydrocele had been punctured immediately after the traumatism it would have been much more like blood. The direct result of the traumatism here was an effusion of blood; clots were formed, and the serum from the blood is what we have just drained off. As I push the canula lower down, we notice some blood yet coming out of the parts.

What will be the result of our operation? In a case of hydrocele, or dropsy of any

serous membrane, the result to be aimed at is to prevent a return of the effusion, which once having occurred, is prone to recur. To accomplish this, we will endeavor to excite an inflammation in the sac, which shall cause its layers to adhere throughout and thus obliterate the cavity. In hydroceles due to gonorrhoea, different measures have been adopted to effect a radical cure; irritating substances, such as tincture of iodine or carbolic acid, have been injected, or the sac has been scraped. Here, the mere evacuation of the fluid will suffice to obtain this result.

FRACTURED RIB.

The next case is one of fractured rib, which, though a trivial accident, may be the source of a great deal of trouble, and it is in view of the possible complications that we must know how to treat such a case.

Fractures of the ribs are produced by direct traumatism, that is, the patient has received a direct blow; has fallen and struck himself; has been caught by falling masses of any kind, or crushed between cars, etc. It is always a local injury.

The first symptom, which becomes evident to the patient, is a stitch in his side as he takes a deep breath. You can readily see that the rib being fractured and its continuity altered, as the thorax expands one end goes one way and the other another way and it is the friction of these ragged ends of bone that causes the stitch in the side and leads the patient to call for the doctor.

As I press with my thumbs, one over one broken end and one over the other, I felt a grating sensation. This sound, taking place over the lung gives a resonance that is quite peculiar to these fractures.

Let us see what might take place if the patient were not treated, for it is only by knowing this that we can fully appreciate the prognosis in the case, not only when he is not treated at all, but when he is improperly treated. If left alone, and the patient be not warned of the danger, the broken ends of this rib will keep on scratching the tissues, and it would suffice, if the man had any diathesis or cachexia (diathesis meaning an inherited condition and by cachexia meaning an acquired vice of the system due to some disease that he himself had contracted) to set up an irritation; this becoming the spot of least resistance, would be the seat for the manifestation of any vice of the system, such as tuberculosis or syphilis. Not only that, but taking his system to be in a normal condition, these ribs rubbing together would cause irritation of the subjacent

pleura—pleurisy—which might soon become purulent and almost destroy the usefulness of the lung. So you see we have a chain of events, the links of which are the result of only a comparatively slight injury. Therefore, you must insist on the proper treatment, which is simply keeping the fractured ends of the ribs in the apposition. You must think of nothing else; put them in splints if possible. To do that, the only way is to bind the thorax and change the form of respiration. You know there are three forms of respiration; the abdominal form, seen in children, where the inspiration is affected by the descent of the diaphragm; the inferior costal type, seen in men, where the inspiratory movements effect chiefly the lower part of the chest wall; and the superior costal type, seen in women, where the movements are chiefly of the upper part of the chest wall. Here we really put corsets on the man; we prevent the chest from expanding by strips of plaster placed about the chest. He will then breathe by depressing the diaphragm. Now there are two ways of putting on these plaster strips. You may apply them only to the affected side, but I take it to be safer to bind the whole chest. Having done this, the man already feels relieved, as the crepitus has ceased.

ISCHIO-RECTAL ABSCESS.

Next I have to show you a case of ischio-rectal abscess. The case has been operated on and is on a fair way to recovery. The abscess has been opened and a large amount of pus evacuated; the case remains, however, very interesting, unassumed as it is one of those instances wherein you see the great simplicity that surgery has at present taken; how affections that were arranged under many different heads, are now classed under one head. If you understand one, you understand all; only the location is different.

This is called an ischio-rectal abscess, because it pointed in the region between the margin of the anus and the ischium. It was a large abscess that did not cause much elevation of temperature and no pain except near the end of its course, when it approached the skin. These have been called cold abscesses, and are found in different parts of the body; at the apex of Scarpa's triangle, called psoas abscess; above Poupart's ligament, called iliac abscess; between the anus and ischium, ischio-rectal abscesses. All these are simply cases of bone tuberculosis. The tubercle bacilli develop somewhere in the back, around or in a bone,

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generally starting about a cartilage. It invades the cartilage, destroys it, and then destroys a portion of the bone. There is an accumulation of pus, which is not taken up by the economy, on which account there is no fever. The reason it is not taken up is that the tubercle bacillus grows very slowly; even in the laboratory it takes two or three weeks or a month before we have a growth. So, in the human body, with but few exceptions, it grows slowly. In consumption the patients last for years, so in hip joint disease, when this bacillus grows in the neighborhood of a cartilage. It grows very slowly and there is a formation of a layer of fibrous tissue about it, the so-called pyogenic membrane, an expression of the old pathologists who thought this membrane produced the pus. The fibrous tissue is merely the result of the chronic inflammation and isolates the abscess from the rest of the body; thus it is that the pus is not taken into the general economy and there is no fever from it; it is locked up. Therefore remember why we call it a cold abscess—because there is no fever with it.

Now imagine a bone to become carious (ulcerated), say about the first lumbar vertebra an abscess forms gradually and becoming larger and larger, the mere force of gravitation causes it to pass in the direction of least resistance. If the abscess exists about the region of the psoas muscle, it will dissect the sheath of muscle and follow it to its insertion at Scarpa's triangle and you say the patient has a psoas abscess, which is only the manifestation of a tuberculosis around a vertebra in the lumbar region. On the other hand, you have an abscess which opens above Poupart's ligament, which presents the same greenish pus found in other cold abscesses. This could only start around or at the margin of the pelvis, and burrowing along the iliac muscle, lifts the peritoneum, and opens at Poupart's ligament an iliac abscess. In the case before us, the abscess which was of the same kind, took neither of the courses above described, but opened between the margin of the anus and the ischium. We ask ourselves whence is this pus. It is from a tuberculous process going on at the inner side of the sacrum, exactly where, I cannot tell.

The abscess points wherever it finds the least resistance, so that I have mentioned three manifestations of the same disease, different only because they exist in different localities.

COMMUNICATIONS.

RESECTION OF THE OPTIC NERVE.

BY L. WEBSTER FOX, M. D.

(THIRD PAPER.)

Since my first paper appeared on the above subject, I have had frequent inquiries made about the instruments I described, as

well as to where they could be obtained in this country. I have had illustrations made of the three most important ones and do not think that a repeated description of them for the benefit of those surgeons who wish to get them, will be amiss.

Fig. 1. Represents the duck-bill retractor which is the most important instrument used in the operation.



Fig. 1.

With this, one overcomes the difficulty in keeping out of the way orbital fat and tissue, as well as making more room for the instruments used in grasping and severing the nerve. Being nickel-plated its concave surface acts exceedingly well as a reflector, which is a desideratum when one is performing the operation with insufficient light.

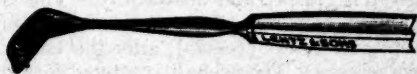


Fig. 2.

Fig. 2. Is an instrument shaped somewhat like a lid elevator, having inserted, in its concave surface, four or five delicate pin points which are pressed against the eyeball, these points pierce the sclerotic coat but are not long enough to puncture it. The assistant pulls the eyeball around and thus exposes the optic nerve.

Fig. 3. Shows the form of the hooks used in holding the optic nerve, one is right-handed, the mate is left-handed.

The instruments designed by Mr. Carter for opening the sheath of the nerve, are just the instruments most useful in resection. In

fact without them it is almost impossible to perform the operation.



Fig. 3.

For those surgeons who did not read my description of the operation published in the *REPORTER* of February 7, 1891, I repeat it: "The lids are separated with the ordinary ophthalmostat; a vertical incision is made through the conjunctiva over the insertion of the external rectus muscle; the conjunctiva is dissected off as far back as the external canthus will permit. This exposes completely the muscle. Two silk threads are then passed through the muscle near its tendinous insertion. These threads will be required in a subsequent stage of the operation, to unite the detached muscle to the eyeball. The muscle is then cut and drawn to the temple side. This exposes the globe. With curved scissors, all tissue is then separated from the eyeball. The optic nerve is found by passing a hook, back of the eye-ball,—: a strabismus hook bent at a right angle. This hook brings forward the nerve, and then the retractor is passed downwards until it meets the nerve, and is then pressed down and out, keeping the adipose tissue out of the way. A second bent hook is inserted under the optic nerve, and also passed backward. A certain portion of the nerve becomes exposed, and with a delicate flat forceps the nerve is grasped and held firmly. This is to prevent hemorrhage from the ophthalmic vein and artery (central) after the cut with the scissors. The eyeball is rotated forward, so that the non-severed nerve becomes exposed and a small piece of its bulbar end is cut off. By keeping pressure on the orbital end of the nerve for a few minutes, all danger of hemorrhage is aborted. The eyeball is then rotated into place, and the external muscle re-adjusted. Over this the conjunctiva is replaced, and is held in position with black silk, which may be removed in three days. Antiphlogistic dressings are applied day and night for several days. Very little reaction follows, and in a week or ten days the eye has assumed its normal appearance, with no disfigurement, and the action of the muscle is complete."

Charles Lentz & Son are the makers, and I must say for them that they have reproduced the English models exactly.

ABDOMINAL NEPHRECTOMY, WITH THE REPORT OF A CASE.¹

¹Read before the South-Western Ohio Medical Society, at Hamilton, Ohio, April 4, 1891.

BY EDWIN RICKETTS, M. D.,
CINCINNATI, OHIO.

It is quite a coincidence that the first modern splenectomy by Pean, and the first modern nephrectomy by Simon, was done in 1869; both of these men deliberately planned these operations. Walcott, however, in 1860, removed a cancerous kidney, after having made a diagnosis of hepatic cyst. It is not my intention to recite statistics, which are decidedly antiquated, as compared with the results of individual operators, such as Tait, Thornton, Savage, of Birmingham, Morris, and others. Even the results of these men may not be striking, yet they are better than those of older operators. At this time the mortality stands at near 40 per cent. at the hands of the best surgeons. In abdominal nephrectomies just now, the results in the hands of a few operators are far ahead of those in lumbar nephrectomies.

CASE.—Mrs. S., aged 33, married, one child eleven years of age. Trouble began in 1880, when she passed bloody urine during attacks of pain located in the region of the right kidney. These symptoms disappeared in time, but she gradually lost flesh and strength up to July 29, 1890, when she called in Dr. J. A. Brown, of Germantown, Ohio, as her family physician. He found her greatly emaciated and decidedly cachectic, with a history for the four weeks past of constant pain in right lumbar region, hectic fever and night sweats; a tender globular mass presented in the right lumbar region, firmly fixed, and extended from the floating ribs to the crest of the ileum forward to within three inches of the umbilicus.

After a few days of observation the opinion was given that it was a suppurating kidney, and an operation for drainage or extirpation was advised. Dr. Donellan was called in and concurred in the diagnosis, and also advised an operation. An effort was made in the way of treatment to improve the patient's general condition by preventive operation, but without any satisfactory result.

No previous history of pus in the urine

could be obtained, nor was pus present at the time of my visit to her, August 19, 1890. At this date I found the condition so tersely described by Dr. Brown, and agreed with him and Dr. Donellan both as to diagnosis and as to the necessity of an operation, notwithstanding the urine was normal in quantity and quality at the present time and had been so ever since the passage of bloody urine ten years before. Upon examination I felt a mass in right lumbar region attached seemingly to the liver; slight jaundice was present, but there was no history of hepatic colic. I advised exploratory incision by way of abdominal section. Consent was given, and I made the operation in the presence of Drs. Brown, Donellan, Horning, and Cochran, the latter gentleman assisting me while Dr. Brown gave the chloroform. I made a six inch incision longitudinally two inches to the right of the median line, beginning at the lower margin of the liver; upon completing my section the right kidney, freely distended and adherent to the liver, was exposed. I punctured it, got pus in considerable quantity, enough to justify an extirpation of the entire kidney, and so proceeded with that object in view. I trocarred all the pus possible after packing sponges about the kidney; I then broke loose the adhesions to the liver, and brought the kidney up into the wound, and ligatured *en masse*, cut away, sponged the surrounding parts well as some pus escaped, and put in a glass drainage tube. At the time of the operation the temperature of patient stood 102.5° F.; pulse 112. The amount of urine secreted during the following twenty-four hours amounted to 40 ounces, and still contained no pus or albumen. By the first week of the following September we had evidence of the presence of a pocket of pus, perhaps at the site of the removed kidney and nearer the lumbar region, where the glass drainage tube could not reach from the front, so we anesthetized the patient, opened from the back, after removing the glass tube in front, carried one end of a well perforated soft rubber drainage tube through and through from front to back, the ends of tubes being tied to the right side of patient. This gave perfect drainage; warm water was forced through from front to back daily. The temperature and pulse soon dropped, and the patient has improved steadily ever since. She has gained 30 lbs. in weight, and is able to attend to her household duties. An insignificant anterior and posterior sinus discharges a small quantity of thin pus at intervals.

THE PNEUMO-THERAPEUTIC INSTITUTE
OF BRUSSELS.¹

BY DR. HOVENI,
OF BRUSSELS.

Last summer I received a visit from Dr. S. Solis-Cohen, with whom I had already been corresponding on the subject of pneumo-therapy. I was gratified by his expressions of astonishment on inspecting the Pneumo-therapeutic Institute. I also felt a pride in being able to teach something to a *confrère* from the country whence progress in every science comes to us.

At the request of my guest of some hours, I shall endeavor to describe the establishment with which I am connected, briefly relate its history, and indicate the physiological and therapeutic actions of air-baths.

In 1879, a number of prominent Belgians who had undergone successful *aëro-therapeutic* treatment at Contrexéville, a French spa, determined to establish an institution for a like purpose at Brussels, and accordingly invited Dr. Tamin Despalles, under whose care they had recovered, and who was already well known through his works on neurology and *aëro-therapy*, to come and create in Brussels an establishment in which all the improvements in his favorite treatment should be found. The invitation was accepted and a limited society was at once organized. The founder, however, did not long live to see the fruition of his work, and was succeeded in turn by a lecturer at the University, an academician among others, and finally by myself.

The Pneumo-therapeutic Institute of Brussels is the largest and most complete in the world; it is situated in one of the healthiest parts of the city, near a small park. As first constructed, it was intended to practise therapy, *aëro-therapy*, including compressed or rarefied air-baths, and also *anæsthesia* by the method of Paul Bert; afterwards, this last method and the *azo-therapy* were given up and numerous improvements were successively introduced; so that now the establishment furnishes the following services:

1. Baths of compressed or rarefied air, with or without supersaturation of oxygen gas.
2. Inhalations of compressed air with expirations into refined air.
3. The sale of oxygen gas in the city, the country, and even abroad.

¹Read by Dr. A. A. Eshner, before the Phila. Co. Med. Soc., June 10, 1891.

4. Electro-therapy, by static and dynamic machines.

I have nothing to say upon these three last points. The works of S. Solis-Cohen have elucidated the treatment by pneumatic differentiation better, if with less prolixity, than any author of our continent. To make the establishment complete, it is furnished with the apparatus of Maurice Dupont, Geigel and Mayr, Hovent, Schnitzler, Solis-Cohen, Tobold, and Waldenburg. I use these apparatus, however, only upon request by my *confrères*, because I have personally ascertained that, while they are of real value, yet, as compared with the air-baths, their utility in several directions is very questionable. In this connection a recent paper by my friend, Dr. Arntzenius, of Amsterdam (*Geneeskundige Courant*, 29 June, 1890), is of interest.

Oxy-therapy and electro-therapy are methods of treatment better known and more widely practised in the United States than in Europe. I will, therefore, not consider them.

I now come to the subject which is really interesting to my American colleagues—baths of compressed or rarefied air. These are given by means of seven iron chambers of varying capacity, some being capable of comfortably containing from two to ten persons. Each chamber is very well constructed; it is supplied with several windows of glass, two centimetres (three-quarters inch) thick; it has a double door, or perhaps better expressed, two doors enclosing a lobby, in which the doctor, entering by the outer door, can shut himself, and then equalizing the pressure, can open the inner door and speedily reach the patient for any purpose without great alteration of the pressure in the chamber. Another smaller door, also duplicated, serves for the purpose of handing to the patient books or whatever may be desired. Electric-bell, elbow-chairs, toilet-tables, manometer, thermometer, hygrometer, etc., are all at hand.

From the chamber so described emerge six pipes leading to the underground tanks of 1, compressed; 2, rarefied air; 3, nitrogen; 4, oxygen gas; the last two pipes are for the purpose of purifying the air, of which I shall soon speak. Each of the first four pipes is attached to a little tank which permits of the measurement of the quantity of air, nitrogen or oxygen, introduced into the chamber, or the quantity of air removed.

The large tanks in which the air or gas is compressed, or rarefied, are ten in number. Each holds several thousands of litres. The

compression or the rarefaction of air or gas is obtained by means of a gas engine of eight-horse power. The tanks will bear seven or more atmospheres of pressure, or a corresponding degree of rarefaction.

The manipulations are as follows: If it is desired to place the patient in a chamber, and the pipe connecting the chamber with the tank of compressed air, for instance, is opened, this compressed air rushes in; its quantity can be regulated according to circumstances. The reverse takes place if rarefied air is to be used; the air of the chamber rushes out and the patient remains in a relative vacuum.

One serious and even capital drawback to the employment of air-baths lies in the fact that in the course of the two hours, the duration of an ordinary sitting, the air within the cabinet soon becomes foul from the processes of respiration, perspiration, etc. The establishment at Brussels is the only one in which this inconvenience is efficaciously overcome. The air is being constantly withdrawn from the occupied chamber, and purified by being passed through several iron Woll's jars with chemicals, to be again introduced, the same degree of positive or negative pressure being always maintained.

It may be desirable to impregnate the atmosphere of the chambers with the vapor of certain medicinal agents; it is an easy matter to place the substance to be used in the path of the air current, or more simply to put some drops of an essence in boiling water into the chambers. I frequently and successfully use pumiline essence.

This is, in brief, all that I think necessary to give a fair idea of the application of the air-baths. I shall now consider their physiological and therapeutic action.

To treat this subject at length, as it deserves, would require too much space; therefore, I shall confine myself to an epitome which, I hope, will serve as an index for the reader. In English medical literature I know only of the papers of the eminent C. Theo. Williams (on air-baths; I shall say nothing of pneumatic differentiation). This is in striking and unaccountable contrast with the profuse medical literature of the continent. I shall quote from some of our authors, but chiefly from my personal experience.

The compressed air-bath more completely expands the pulmonary vesicles and increases their elasticity; the diaphragm and the base of the lungs descend lower; the respiratory process is more perfectly and less frequently

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performed; the peripheral circulation is less active, with some degree of decongestion of the skin and the mucous membranes (nasal, laryngeal, pulmonary, etc.); the pulse is less frequent and more full; the appetite and strength increases rapidly; the nervous system is undoubtedly invigorated. One may observe that these effects are carrollaries of one another and result either from mechanical or chemical action; indeed, the oxygen of compressed air is no longer oxygen, but some form of ozone.

The rarefied air-bath has not been so well studied; nevertheless, it is employed with much success by some practitioners, who seek in it a reproduction of mountain atmosphere. It has also been recommended for rickety children, when the thorax is deformed. Recently it has been used alternately with the compressed air-bath, when a doubt exists as to whether a patient should be sent to the mountains or to the seashore. The therapeutic use of the air-baths are very numerous, but easily deduced from the foregoing considerations.

Asthma is the principal affection for which compressed air-baths are employed. 80 per cent. of recoveries are obtained after twenty to sixty sittings. During the first sitting the dyspnoea disappears when the pressure of air is sufficient; this result becomes permanent only after a number of sittings. I remember but one case, that of an American patient coming from Oregon, in which the paroxysms reappeared as soon as the pressure was lowered. The patient was very well while under pressure, and I have frequently kept him enclosed for eight or ten hours instead of two. I diagnosed a traumatic medullary lesion, limited to the respiratory center.

In pulmonary emphysema, the air-bath empties the vesicles and increases their elasticity, so that the dyspnoea diminishes. The first sitting is usually followed by a notable improvement. As in asthma, the success is generally striking and permanent. Pulmonary congestions, pulmonic processes preceding or following pneumonia and hæmoptysis, are cured mechanically, since the compressed air provokes anæmia of the pulmonary tissues. I have some absolutely confirmatory observations. Chronic bronchitis and bronchorrhœa are always improved, so far as concerns dyspnoea, cough, expectoration, and general health. The first effects of the treatment are an increased expectoration up to the point of completely ridding the lungs of mucus, and simultaneously a decongestion of the respiratory mucous membranes. The last action must be invoked in explaining

the beneficial influence of compressed air in coryza, chronic pharyngitis and laryngitis, and in that exaggerated susceptibility of the mucous membranes, as a result of which the patient is constantly exposed to the danger of catching cold. I have recorded two cases of chronic amygdalitis, in which resection had been contemplated, and in which I obtained complete cures by compressed air-baths.

In whooping-cough, "the beneficial action of air-baths is undeniable," said Dujardin-Beaumetz. The cure is obtained after ten to fifteen sittings; and generally the child gains from one to three pounds in weight. Jaccoud charges with gross neglect the physician who does not submit his consumptive patient to aëro-therapy. Oertel thinks the compressed-air treatment far superior to climatic treatment in any country. Prof. Bertin (Montpellier) has recorded five cases of recovery in consumptives in the third stage.

Heart disease had long been considered the only drawback to aëro-therapy, but since I have successfully treated a number of cases with cardiac complications, I no longer hesitate to treat such cases, only using certain precautions.

In catarrhal deafness compressed air effects a natural catheterism. I have not infrequently seen patients suffering with asthma or other complaints emerge from the chamber declaring that their hearing was better than for many years.

Dujardin-Beaumetz says: "Compressed air-baths are to be preferred to any other method of treating chlorosis, anæmia, diabetes, albuminuria, and gout."

Obesity, also, is favorably influenced as a result of the acceleration of organic combustion and the more active elimination of urea and carbonic acid.

In conclusion, I must add that Dr. Arntzenius has cured some cases of neurasthenia, and that I have recorded three observations of dysmenorrhœa being permanently cured by a pneumo-therapeutic course. I think these results are due to the general invigorating power of the treatment.

If I should quote all the authors who have written upon the subject of air-baths, not only in France, where the treatment was originated, but in Russia, Scandinavia, Holland, Germany, Italy, and Spain, the list would be a very long one. I wish only to note that none of them has expressed an unfavorable opinion. I am convinced that the treatment which I have expounded is entirely reliable, and I shall be happy if my

paper contributes to make the medical profession of the United States acquainted with the better method of pneumo-therapy.

(For discussion, see Society Reports.)

SOCIETY REPORTS.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, June 10, 1891.

The President, John B. Roberts, M. D., in the Chair.

DR. HOVENT, OF BRUSSELS, PRESENTED A PAPER ON THE PNEUMO-THERAPEUTIC INSTITUTE OF BRUSSELS.—(See p.11.)

DISCUSSION.

DR. THOMAS J. MAYS: I am a firm believer in the efficacy of compressed and rarefied air in all kinds of chest diseases as well as in general disease of the body. My experience has been limited to the use of these agents with the Waldenburg and Cohen-Richardson apparatus. These apparatuses are of value in many forms of lung disease, especially in incipient phthisis, bronchitis, and in asthma. You cannot use rarefied and compressed air indiscriminately. Rarefied air is suited for some conditions, and compressed air for others. I think also that in certain forms of incipient phthisis compressed air will tend to aggravate the disease. If the temperature is above 100° its use will tend to increase it. I have given up the use of compressed air alone, and now employ oxygen and nitrous oxide under pressure, either with or without air.

In Berlin I saw cabinets similar to those described in the paper. They certainly do a great deal of good, but strange to say, most of the writers speak of the value of compressed air without saying much of the value of rarefied air. I think that by immersing a patient in rarefied air you obtain the same effects as you would by placing him at a high altitude. I do not think that the good comes so much from the effect upon the lung as from the influence which is exerted upon the whole body. By taking off part of the pressure from the surface the resistance to the circulation is diminished, and in that way the blood is permitted to reach the periphery and nutrition of the outlying parts is stimulated. I think that in this lies the great and chief value of mountain air in the treatment of consumption.

The influence of compressed air upon hearing has been referred to. It has been found

in the cabinets at Berlin that the compressed air increased the sense of hearing of every one, but, so far as I know, this is only temporary. Those who were hard of hearing will improve for a time, but soon the hearing is as bad as before.

DR. S. SOLIS-COHEN: Except from reading, I know very little about this particular branch of pneumo-therapeutics, my experience being confined to the method by which the patient inhales from or exhales into compressed or rarefied air. The method of immersing the patient in an atmosphere of modified pressure requires expensive apparatus, but from what I saw in Brussels, and from the examination of patients with a comparison of their previous histories, I believe that the method accomplishes all that Dr. Hovent claims for it. I went into the cabinet myself, but did not remain long; the noise in the ears and the sense of fullness in the head were sufficiently unpleasant to make one wish to get out as soon as possible. All who have used this method, with the exception of Waldenburg, claim that it is superior to the differential method, though they admit the greater availability of the latter. I have had no opportunity of comparing the two methods, but my experience with the differential method has been thoroughly satisfactory. The remark of Jacoud, quoted by Dr. Hovent, will well bear repetition; I would, perhaps, slightly modify it and say, "that whoever fails in a suitable case of phthisis to give his patient the benefit of a trial at least of aëro-therapy, fails to do his duty." I do most sincerely believe that the routine writings of prescriptions, with a neglect of the mechanical means so far superior in many cases, is a failure on the part of the medical profession to do its duty toward those whose lives are, humanly speaking, entrusted into its hands. My personal experience now extends over ten years, and I should not like any patient of mine to be deprived of the opportunity of a trial. Inhalation of compressed air will not work miracles. It will not revive the dead. But it will help the patient to fight the disease. It dilates the air-cells, improves the quality and distribution of the blood, and gets rid of accumulated decomposing products which may give rise to septic fever.

DR. JAMES C. WILSON: I would ask whether it is not the experience of patients that after a time these unpleasant sensations, due to disturbance of circulation, diminish?

Dr. Cohen has more right than any one else to arraign the profession for the neglect of these mechanical measures, for he has

been a pioneer in this country, and a consistent practitioner in this particular branch of therapeutics. At the same time, I am at a loss to understand what view a man occupying Dr. Cohen's position can take of the decadence of the enthusiasm which followed the invention of the pneumatic cabinet, four or five years ago. There was, unquestionably, a most excellent device for the practice of such methods as Dr. Cohen advocates. Many medical men availed themselves of this apparatus, but now one hears nothing of the pneumatic cabinet. Many who at first claimed excellent results from the apparatus have abandoned its use.

DR. LAWRENCE F. FLICK: I have no personal experience with this mode of treatment. I, however, believe with Dr. Mays, that compressed air may do considerable harm in a certain class of cases. I have seen some things in practice which tend to confirm that view. Where the disease is in an acute stage the quieter the circulation the better for the patient. I have seen a case where even a little exertion more than was prudent precipitated a general tuberculosis where the disease had been simply local. I believe that there is a class of cases where the application of compressed air would be of benefit—cases in which the acute stage is passed, and there is considerable material to be gotten rid of.

It seems to me it is hardly fair to arraign the profession for neglecting the use of this method of treatment. It is scarcely right to deal in a general way with this subject without giving detailed accounts of the benefits of the treatment. If such wonderful results are obtained, we should be shown those results.

DR. SOLIS-COHEN: In reply to Dr. Wilson, I would say that there is no question that tolerance to the effects of immersion in compressed air is gradually established just as tolerance to the effects of altitude is established.

Allusion has been made to the absence of reports of the effects of rarefied air-baths. These have been tried, but abandoned. Paradoxical as it may seem, it is the compressed air-bath and not the rarefied air-bath that simulates the therapeutic effects of mountain residence. The complaint of Dr. Flick is not well founded. These methods have been in use since 1838, and numerous cases are on record. I have reported a few, but not many, because at this late day it is superfluous.

In reference to the pneumatic cabinet, the methods employed in exploiting it were a

sufficient reason why it should not find favor with the bulk of the profession. Then, again, it is a very troublesome and expensive means of doing what can be done much more cheaply and simply. Many physicians of high repute, however, still use it. Among others I may cite V. Y. Bowditch, of Boston. We may rest assured that no physician who has used pneumatic treatment will ever abandon it. The question of apparatus is secondary. The pneumatic cabinet has the same disadvantage that belongs to the pneumatic chamber, and that is, that the patient is compelled to visit the physician to obtain the benefit of the treatment. With portable apparatus, which can be placed in the patient's home, this objection is overcome. If I take any credit to myself it is for simplifying and cheapening the machinery so as to make this possible. As a matter of course, pneumatic measures have their indications and counter-indications, as atropine, morphine, bromides, and drugs in general have theirs. No one uses atropine to produce bromide effects. Air has its definite field of use, just as atropine and bromide have theirs.

Nobody uses compressed air in acute tuberculosis. This was long ago laid down as a counter-indication by Waldenburg and others. It is not to be used in certain diseases of the heart, or in cases with large cavities with extensive septic processes. Between cases with acute processes and the stage of extensive excavation, as well as in the very early stages of so-called incipient phthisis, lies an extensive field for the employment of mechanical measures. They are used not as exclusive measures or panaceas, but to produce certain definite and highly desirable effects that cannot be produced by any other agent; certainly not by drugs, whether creasote or iodoform, hypophosphites, or cod-liver oil, tuberculin, or cantharides. Especially with patients who would be benefitted by mountain climate, but who cannot get away from home, will pneumatic treatment prove a valuable substitute. Some patients have even taken their machines to the mountains, because they dreaded to be deprived of the good effects. I repeat that the treatment works no miracle, but every patient has a right to the additional chance for life it may give him, and the physician who deprives him of that right is at least negligent. We will never save all the phthisis cases that can be saved until we get rid of the idea that "specific medication" is a possibility, and concentrate our attention on improving the

patient's general and local vigor and nutrition.

DR. MAYS: I think that the principal reason why the pneumatic cabinet has fallen into disuse is because it cannot be used in private offices. In hospitals it can be used and is used.

In regard to the use of compressed air I would say that I made no reference to acute diseases when I cautioned against its indiscriminate employment; but thought of sub-acute or chronic pulmonary affections. I have in mind now a case of catarrhal phthisis of about eighteen months' standing, which I am quite sure became aggravated after the third inhalation of compressed air. She became worse in every respect, and died about two months later. I have knowledge of other cases who were served somewhat in the same way, and I seriously think that great care should be exercised until we know its influence on each case.

I certainly think that Dr. Cohen must be mistaken when he says that the effects of compressed air are the same as those of the rarefied air of mountains. Not to my recollection have I seen any one else express this view.

SELECTED FORMULÆ.

TREATMENT OF PIGMENTATION IN PREGNANT WOMEN.

In the *Journal de Médecine de Paris*, the following ointment is recommended to be rubbed into the affected parts twice daily, to remove the pigmentations which so often disfigure pregnant woman:

R	Cocoa butter,	
	Castor-oil.....	aa 3 ij.
	Oxide of zinc.....	gr. v.
	Yellow oxide of mercury.....	gr. ij.
	Essence of rose, enough to perfume.	

—*Therapeutic Gazette.*

THE CURE OF PERSISTENT DANDRUFF.

The following is recommended in the *Lancet* by Mr. Purnell for the relief of this troublesome affection: An ounce and a half of iron wine, one drachm of liquor arsenicalis, three drachms of syrup, water to two ounces. Of this one drachm is to be taken in water after meals. Then an ointment consisting of four drachms of the red oxide of mercury ointment, an ounce and a half of benzoated lard, and two minims of the essence of bergamot should be rubbed thor-

oughly into the roots of the hair, and its use continued for some time.

ON ICHTHYOL VARNISHES.

Unna undertook experiments with various substances in order to obtain an ichthyol varnish which was soluble in water and which would offer the advantages and none of the disadvantages of other ichthyol preparations. He recommends the following as the best:

R	Ichthyol.....	40 parts.
	Starch.....	40 "
	Sol. of albumin.....	ca. 1-1½ "

The starch is to be evenly mixed with the water, then the ichthyol is to be well rubbed up in it, and lastly the albumin is to be added.

He also advises another varnish containing carbolic acid, but as this latter would precipitate the albumin, the formula is a little different:

R	Ichthyol.....	25 parts.
	Carbolic acid.....	2½ "
	Starch.....	50 "
	Water.....	22½ "

The ichthyol and carbolic acid are to be dissolved in the water by means of heat and the starch is then added to the solution.

Both of these varnishes dry rapidly and completely, do not dissolve under the influence of sweating, and can be easily washed off. They are applicable for the treatment of various circumscribed cutaneous diseases, and are recommended for acne, rosacea seborrhoica, rosacea simplex after frost-bite, and especially in lupus erythematosus. Also in certain forms of eczema, in intertrigo, in his tubercular eczema (a large pustular eczema occurring especially about the natural openings of the face, associated with tubercular glands and occurring in children, generally described as of a strumous type—Elliot), and again in erysipelas.

To the ichthyol varnish chrysarobin (2 to 5 per cent.) can be added, or pyrogallol, resorcin, sulphur, etc., and consequently it becomes useful in the treatment of all parasitic eczemas, of psoriasis, or of other cutaneous diseases presenting circumscribed lesions and patches. He suggests that when a new drug is added to the varnish an equal amount of water or of some oil, preferably linseed oil, should likewise be mixed with it so as to facilitate its incorporation and to preserve the thick-fluid consistency of the preparation.—*Jour. Cutan. and Genito-urin. Dis.*

THE MEDICAL AND SURGICAL REPORTER.

ISSUED EVERY SATURDAY.

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PROFESSOR OF PHYSIOLOGY, UNIVERSITY OF PENNA.,
EDITOR AND MANAGER.

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The Editor will be pleased to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

LEADING ARTICLE.

MODIFICATION OF INFECTIOUS INFLUENCES BY MICRO-ORGANISMAL ANTAGONISM.

In a leading article published in *THE REPORTER*, (May 9, 1891,) the writer indicated a four-fold possibility of influencing infections, by the utilization, first, of the products of bacteria, which in a number of instances have been found to possess an inhibitive power over further development of the organisms from whose activities they have originated; second, of the antagonistic relations of certain bacteria toward other micro-organisms; third, of the antibacterial influence of various substances included under the general term, drugs; and finally, of those extraneous conditions which act unfavorably to the development of disease germs. The first of these was incidentally considered in relation to the recent attempt of Prof. Koch to overcome the tubercular infection; and sufficient was said to suggest the scope of its possible utility.

In a somewhat less, but nevertheless existing, degree of importance, the second of these considerations may be regarded; especially as there is no little evidence from laboratory sources that such an antagonism clearly exists between many growths. Moreover most of those micro-organisms whose influence is sufficient in contaminated cultures of pathogenic bacteria to destroy, or retard the growth of the latter, are as a rule saprophytes, nonpathogenic so far as the human economy is concerned. In what manner this antagonism is productive of its visible results is not understood; although it may be conjectured that two factors enter into the case, the simple effect of crowding and exhaustion of the elements necessary to life by the more actively vegetating growth, and the elaboration of the latter of some material deleterious to the existence of the other species. It is of interest in this connection to recall as an illustration the suspected influence exerted against tetanus by the suppurative micro-organisms.

It is a well-known feature of tetanus that the affection is peculiarly liable to develop in deep punctured wounds, such as are not apt because of the relative absence of oxygen to permit any marked growth of the pyogenic micro-organisms; while on the other hand in case of open, freely suppurating sores exposed to similar circumstances of infection, as in the feet of horses, the disease is not nearly so apt to manifest itself. Such a fact may be readily explained by the supposition that where free growth is accorded to the pyogenic bacteria there is formed some matter which exercises distinct retarding influence upon the tetanus micro-organisms, or that the full development of the former prevents by actual space encroachment the advance of the latter. The fact that suppuration is in a slight degree, at least, present in these deep, narrow wounds from which tetanus originates, does not militate against the supposition, since by the exhaustion by the pyogens of the limited amount of oxygen derived from the air supply a favorable circumstance is afforded the tetanus bacilli, which are essentially non-aerobic, the suppurative bacteria, however, being unable, from want of free ingress of air, to advance to any proportion sufficient to act against the tetanus germs. In the same connection it is to be recalled that Garré, several years ago, called attention to the fact that in tube cultures Flügge's fluorescent bacillus was persistently and fully antagonistic to the growth of typhoid bacilli and the pneumobacillus, and exercised a retarding influence upon the cholera spirilla. So too Pawlowski has come to the conclusion that the cure of anthrax is possible by bacterio-therapeutic means, this end being attainable by the subcutaneous injections of various micro-organisms at the point of entrance of the anthrax bacilli into the economy, the antagonistic germs employed by this investigator being Friedländer's diplococcus of pneumonia, the staphylococcus aureus, the bacillus prodigiosus, and the streptococcus of erysipelas. In connection with the last micro-organism the results of Pawlowski have been fully corroborated by von Emerich and Mattei. It is relevant, too,

to recall, as mentioned by Garré, the rapid disappearance of the cholera germs from the effluvia in the presence of the saprophytes which are abundantly found. The researches of Pasteur, in relation to anthrax and fowl-cholera, and those of Heer upon typhoid fever and the yeasts and thrush and diphtheria bear upon the question in point. The numerous attempts toward the cure of malignant tissue growths by inoculation of such germs as the streptococcus of erysipelas are to be mentioned in this same category; although as an illustration these endeavors have little force from the very conflicting reports of results and from the fact that such growths are not even probably proved to be the products of micro-organismal activities.

The ultimate importance of this, as of any other medical subject, centres in its possible value in the management of disease. Herein at present, however, its demonstration practically fails. Under natural conditions the coincidence of infections in the economy has not been sufficiently studied in relation to the heightening or lowering of the consequent symptoms and little inference can be drawn until further attention is attracted to this feature. It is interesting, however, to cite here the observations of Woodward in relation to the affection to which the term "typho-malarial fever" has been applied, a type of disease in which from the statistics collected by the writer named from the records of the civil war the mortality is three or four times less than in the uncomplicated type of typhoid fever. Of course, this illustration, too, is open to the very grave objection that the affection named is not surely proved to be a combination of the malarial and typhoid infections; but in its clinical course it presents such a combination of symptoms, that, until it is shown to be independent of the combined pathogenic influences, it cannot well be overlooked. With in the recent experience of the writer there occurred in a child an attack of croupous pneumonia of the apex of the right lung, during the course of which a mild attack of varicella appeared; there was the usual

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severity of symptoms of the pneumonia except in the case of the mental disturbance which although usually pronounced in such cases in this was of exceedingly mild character, and the disease ended by lysis. The varicella was insignificant, and it was particularly noted that it exercised no exaggerating influence upon the already existing pneumonic process.

It is true that there is nothing irrefutable, nothing decisive in these citations; but thus grouped they give some support to a theory which seems quite plausible and apparently only awaits the discovery of the surely existing proof. As to its therapeutic limitations, could the establishment of the principle upon sound clinical and experimental grounds be fixed, a field of the greatest importance opens. There can scarcely be imagined within human power so ready a means of modifying the severity of epidemics or the eradication of the malignant infections than by the introduction into the midst of the infected population an influence of infectious character having antagonistic tendency toward the primary disease cause. In their treatment, too, of the individual case there must be conceded an advantage if the promise of the subject be in any degree fulfilled. At the most the idea is but a step removed from the practice of vaccination in small-pox, in which case a virus, modified in intensity by passage through the bovine economy, grants immunity from and reduces the severity of already established infections of variola; possibly many of those who are disposed to regard vaccinia as a disease entirely separate from small-pox may look upon its results as illustrative of the applicability of the antagonism existing between micro-organisms.

CORRESPONDENCE.

"ARSENITE OF COPPER IN DIARRHOEA."

EDITOR OF THE MEDICAL AND SURGICAL REPORTER.

Sir:—Allow me to correct a statement in the last issue of THE REPORTER which is

calculated to create a wrong impression. In referring to the employment of arsenite of copper in diarrhoea, page 792, you have quoted Dr. Hintz, from a French journal, and suggest that he took his idea from my work in bringing this remedy to the attention of the profession. It is due Dr. A. F. Hintz, of Idalia, Colorado, to state that his paper appeared originally in the issue of the *Therapeutic Gazette* for February, 1891, and that in his communication, he mentioned the fact that he had first learned of the value of the drug from a communication which I published as early as 1888; he also referred to other papers of mine on the same topic.

Very Respectfully,

JOHN AULDE, M. D.

4719 Frankford Ave., June 20, 1891.

BOOK REVIEWS.

THE POCKET MATERIA MEDICA AND THERAPEUTICS. A resumé of the action and doses of all official and non-official drugs now in common use. By C. Henrie Leonard, A. M., M. D. The Illustrated Medical Journal Co., Detroit, Mich., 1891.

This volume is a pocket manual upon *Materia Medica* and *Therapeutics*, in which the author has incorporated all drugs of sufficient merit to warrant attention, whether official or otherwise, and includes remedies of as late introduction as 1891.

The general arrangement of the book embraces the pronunciation, genitive case ending, common name and dose, including the metric dose. *If a plant*, the part used, habitat, natural order, and description of plant and flowers, with its alkaloids, if any. *If a mineral*, its chemical symbol, atonic weight, looks, taste, where found, and its peculiarities. The action and uses of the drug, its antagonists, incompatibles, synergists and antidotes. Official and non-official preparations, with their medium and maximum doses, based so far as possible upon the U. S. Dispensatory.

Typographically, the book appears to be free from serious error, for which fact the publishers and author are to be congratulated.

Altogether, it is a handy manual for the student, physician or druggist, and it can be safely recommended as the most complete small book issued on this subject,

A COMPEND OF GYNÆCOLOGY. BY HENRY MORRIS, M. D., late Demonstrator of Obstetrics and Diseases of Women and Children in the Jefferson Medical College, Philada., Etc., With forty-five illustrations.

These recent additions to the literature of a department of medicine so rapidly widening its bounds each year, should rather be termed a *digest* than a "quiz-compend," for it is not arranged in questions and answers, but gives a concise epitome of each subject treated. The author has been fortunate in the selection of excellent illustrations, and some features of his book are especially worthy of notice, including his original cuts. The chapter on gynecological examinations is admirably suited to both student and practitioner, and the writer has succeeded in incorporating many very practical points. The portion of the work devoted to diseases of women, combines the latest ideas with an arrangement commendable for its exactness. A good feature also is the diagram of the proper positions of operator, assistants, nurses, instruments, etc., during ovariectomy. The description of this operation is well-timed and well systematized. In reading any book we naturally find things to hope for, but in reviewing this one the praise-worthy features entirely overshadow any defects it may contain, and the author has amply accomplished his object, in producing a book of use alike to beginner and busy practitioner.

PERISCOPE.

THERAPEUTICS.

ANTIPYRESIS BY DRINKING LARGE QUANTITIES OF COLD WATER.

Although he is a warm advocate of the bath treatment, Prof. Cantani regards slight reductions of temperatures as preferable in many cases to the marked antipyresis produced by a cold bath. During many years he has obtained this result by letting the patient drink large quantities of cold water, and administering, at least twice daily, a large enema of some cold slightly antiseptic solution. The same method of antipyresis is not equally efficient in all cases of fever; in typhus, for example, the most marked reductions of temperature are obtained by the drinking of large amounts of cold water, whilst in typhoid, cold enteroclysms yield better results. In typhus the patient is given from five to six quarts, and sometimes even eight quarts of cold water during the twenty-four hours, and the windows of the room are kept open day and night. In some of the cases the duration of the disease was

markedly shortened, the temperature in one case being reduced from 41° to 37° on the eighth day. In typhoid fever large quantities of cold water are introduced into the bowel, and the effect of these is supplemented by letting the patient drink as much as possible of cold water. It was found by a large number of observations that after each enteroclysm of two quarts of water the temperature fell 0.5° – 0.8° C. in the axilla, and this reduction was maintained for two, three or more hours. The water injected, which had a temperature of 11° , was usually evacuated in ten to thirty minutes, and then had acquired a temperature of 35° – 37° C.

Both of the above mentioned methods of antipyresis increase the quantity of urine and diminished its specific gravity, especially the drinking of water. This proves that the cold water is absorbed in large quantities and then cools the entire body and even the blood, an effect more certainly obtained than with other hydro-therapeutic methods. Thus the internal organs which have the highest temperature during fever are cooled, the tissues are permeated and cleaned by the water and freed of ptomaines, and this takes place without disturbances of any kind, except occasionally a slight chill.

In ileo-typhus, the author has used for many years enteroclysms of two quarts of cold water (11° – 12° C.) containing three, six or ten grammes of tannic acid and ten to fifty centigrammes of crystallized carbolic acid, and usually also one to two grammes of hydrochlorate of quinine. These are repeated twice daily, and their effect is sometimes astonishing. They prevent meteorism, or when it is already present, they cause it to disappear after two or three applications. The intestinal symptoms are reduced to a minimum, and the fever reduced and its duration shortened. In typhoid fever, if enteroclysis is employed at the commencement, it is possible in the majority of cases to abort the disease.—*Centralblatt f. allgem. Pathologie und path. Anatomie*, February 1, 1891.

THE TREATMENT OF MALARIA.

Laveran finds that in the contest between the organism and the hematozoons, the leucocytes play an important role. It is a well-recognized fact that if an insoluble and finely-pulverized substance be injected into the blood of an animal, the leucocytes rapidly invade this powder and charge themselves with its elimination from the blood (Ponfick, Hoffman, Langerhaus).

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The reseaches of Metchnikoff prove that the leucocytes not only invade inert powders and the bodies of microbes, but also, in a great number of cases, the living pathogenic microbes, and that this property, known as *phagocytosis*, plays a very important role in the evolution of infectious diseases and in the phenomenon of immunity. The cells of the splenic pulp and those of the endothelium, of the connective tissue, and of the pulmonary epithelium participate in this power. He has also concluded that the paroxysm of the fever persists during the life of these microbes in the blood, ceasing only when the parasites become the prey of the phagocytes. Especially is this marked in relapsing and malarial fever. The resistance which the microbes exert against this action of the leucocytes may be of long duration if they be lodged in the spleen or in the marrow of bone.

Wysockowitsch has noticed that the spores of the *bacillus subtilis* lodged in the spleen were still living at the end of three months, an interesting fact in a point of view of the study of latent microbism.

Metchnikoff, Golgi Gamaleia, and others insist upon the destructive action of heat upon the microbes, while, on the contrary, cold diminishes the activity of the phagocytes. It is well known that an organism placed in the best general condition will resist most successfully the inroads of the pathogenic microbes, whilst all debilitating causes militate against the cure of malaria. Laveran himself has observed in animals whose blood contained hæmatozoa, that under the influence of an abundant alimentation the microbes disappeared, while dilatation favored their development. The anæmic diseases—over-fatigue, ill nourishment—are attended with frequent relapses of the fever, and the salts of quinine themselves seem to become powerless in preventing these relapses. On the contrary, under the influence of only a good regimen and rest, frequently the condition of malarial patients will ameliorate, the anæmia grow less, the relapses less frequent, and a cure may occur without the intervention of a more active medication, simply because the organism has been placed in the best hygienic condition.

All the tonics have, consequently, a favorable action upon the progress of the disease, and foremost among these may be placed wine, coffee, and arsenious acid. Arsenic taken in small doses is of great service in the treatment of rebellious fevers with the malarial cachexia. If given in large doses,

however, relapses of fever will often be produced, and the condition of the patient aggravated. Hydrotherapy is valuable, always used as a tonic medication. It succeeds sometimes when other medications have failed. It is well to know, however, that the first treatment may provoke a relapse; hence it is necessary to proceed with prudence, beginning with short and lukewarm douches before arriving at cold douches, not touching at first the spleen, and prescribing some doses of quinine at the same time. One can readily understand that a cold douche, especially if applied over the splenic region or following a paroxysm, will cause contraction of the splenic vessels, driving the hæmatozoa into the circulation. The malarial patients who in thermal stations—Vichy, for instance—take these waters both internally and in the form of baths, often have relapses at the beginning of the treatment, when they do not proceed with prudence. The change of climate is often beneficial to these patients, because the great heat of malarial climates is very debilitating, giving rise to exhausting sweats, nights without rest, and dyspepsia—all of which are corrected in a better climate. Quinine is of invaluable service in the treatment of these fevers, especially acting as a specific in the chronic forms. It has a very powerful destructive action upon all microbes, especially upon the protozoa, to which group the hæmatozoa belong. These rapidly disappear from the blood of patients who are submitted to a course of quinine medication. The spherical bodies and the flagellate forms disappear first. The treatment must be continued for some time to insure entire destruction of the microbes. It is probable that the phagocytes invade more readily the hæmatozoa when they have been killed or benumbed by the salts of quinine, but that the activity of the phagocytes is not directly influenced by the quinine. *La Médecine Moderne*, February 19, 1891.

ACTION OF OPIUM AND MORPHINE ON THE BOWEL.

Spitzer has published (*Virchow's Archiv*, cxxiii, Heft 3, 1891) an experimental investigation of the action of opium and morphine on the intestinal canal. His experiments were carried out on frogs, rabbits, and men; his objects were to increase our very defective knowledge of the action of opium on the intestine, and to determine whether, as is generally assumed, opium is superior to morphine as an anti-diarrhœic and anodyne in intestinal affections. In frogs the bowel

was exposed and kept moist with saline solution. Very small doses of watery extract of opium given subcutaneously sufficed to diminish the sensitiveness of the bowel to painful stimuli, while leaving intact the sensitiveness to stimuli which simply call forth peristalsis, the skin sensitiveness being also unaffected, and there being no general narcosis. In this condition the action of the opium may conceivably be exerted on the brain, or the spinal cord, or on nerve centres in the wall of the bowel. The author concludes it cannot be on the brain, as the same result is obtained with decapitated frogs; he also thinks it cannot be on the cord, as its functions are otherwise left intact. The action must, therefore, be on the bowel locally, and this opinion is supported by the fact that even smaller doses given *per os* have an equal effect. That opium acts locally as an anodyne on the intestinal canal, apart from its general action, he further proves by giving a frog strychnine, and then tying the bowel midway between the stomach and anus. Stimulation applied to either half of the bowel equally called forth tetanic convulsions, but when a solution of opium was injected into the lower half, its sensibility was found to be greatly lessened in comparison with the upper half. Spitzer holds that the opium does not paralyse the ends of the sensory nerve in the bowel, but sensory ganglia which, he assumes, lie in the course of the sensory nerves in the wall of the canal. These get an undue share of the opium as the alkaloids are excreted from the blood into the intestine, are absorbed into the blood again, and again excreted into the intestine, so that there is a constant circulation of them in the blood vessels of the intestinal wall. The motor ganglia are also probably affected in the same way as the sensory, but either not so powerfully, or the action is not so readily demonstrable. Larger doses are required to diminish peristalsis than to diminish sensibility in the bowel. The diminution of peristalsis may be due to paralysis of motor ganglia in the bowel, or to a stimulation of the inhibitory centres in the cord from which the splanchnic nerves arise. Paralysis of the sensory nerve terminations in the wall of the intestine does not occur, because after very large doses of morphine the peristaltic movements of the bowel become very marked, and experiments pointed to the conclusion that the diminution in peristalsis was very largely due to an action of the opium in paralysing the motor ganglia in the walls of the intestinal canal. Large

doses caused great increase of bowel peristalsis before general spinal tetanus was induced. The author thinks this is due to paralysis of the spinal cord, and consequent paralysis of the inhibitory action exerted by the splanchnic nerves. In this condition, however, the sensitiveness of the intestine to painful stimuli is much diminished. Morphine has the same action in every way, and quantitatively the activity of the opium is proportional to the amount of morphine it contains. The other alkaloids of opium have very little action on the bowel. On rabbits observations were made after exposing the bowel while the animal lay in a warm bath of saline solution. Spitzer confirms the well known experiments of Nothnagel, in which he found that irritation of the bowel with sodium chloride is not nearly so effectual in increasing peristalsis after the administration of opium or morphine. If a portion of bowel be completely isolated and the same experiment repeated, then peristalsis is not interfered with; this result is regarded as proving that in this case the opium acts on the spinal cord, and diminishes the inhibitory action of the splanchnic nerves. Spitzer, however, points out that irritation of the bowel from without with sodium chloride scarcely corresponds to physiological peristalsis or increased peristalsis after purgatives or irritation from within of the mucous membrane, as the peristalsis takes place towards the pylorus, and is very inconstant in amount. He therefore irritated the bowel by injecting into it a 15 per cent. salt solution, colored with indigo-carmin. The rate at which this solution progressed down the intestine was observed in normal animals, and was found to be two or three times slower after opium or morphine, the peristalsis being also much more gentle and regular in the latter case. Even after complete isolation of a portion of the intestinal canal from its mesenteric nerves, opium greatly diminishes the peristalsis. Opium given subcutaneously acts exactly to the same extent, and no better, than morphine subcutaneously, its activity being proportional to the amount of morphine it contains. In healthy men opium by the mouth acts somewhat more powerfully on the bowel than when given subcutaneously. The reason probably, is that the morphine is only slowly abstracted from the opium, and thus acts gently along the whole length of the bowel; it is not so quickly absorbed as pure morphine is, and in consequence does not produce so marked a general action. In diarrhoea, opium *per os*

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is the most powerful—more so than opium extract or morphine subcutaneously, or morphine by the mouth. In slight intestinal pain opium by the mouth is the best treatment, as we get the desired analgesia with small doses and without constitutional effect, the local action on the bowel being probably sufficient; in very severe pain hypodermic injection of morphine is most effectual. [The author does not discuss diminution of intestinal secretion as a factor in the astringent action of opium.]—*Brit. Med. Jour.*

A COMPARISON BETWEEN SALICIN AND THE SALICYLATE OF SODIUM.

Dr. Alexander Haig has recently read a paper before the Medical and Chirurgical Society of London on the comparative merits of these two drugs in the treatment of acute articular rheumatism. He bases his comparison on the relative power of the two drugs to excrete, or to stimulate the excretion of, uric acid. He has found that the salicylate of sodium has about thirteen times the excretory potency of the other drug, and he thinks he has seen that their power to interfere with the course of the disease has been approximately identical with their liberation of uric acid. His contention is that all those plans of treatment of acute rheumatism that have proved beneficial have been so in an exact proportion to their uric acid secerning power. According to Dr. Haig's reasoning, acute rheumatism is caused by the presence of uric acid, primarily, in the blood and that being driven thence by a high acidity, it is precipitated in the joints, and that this precipitation of the acid, together with the fact of the non-destruction of the acid furnish us with the most manageable theory as to the inflammatory processes and pyrexia of the malady. The rise of temperature adds to the acidity and the precipitation of acid in the joints is more complete than in gout. There may be other causes besides pyrexia that will increase the acidity, such as suppressed perspiration and chilling, tonsillitis and other local inflammations, and the ingestion of acids and acid-forming foods, all of which are predisposing causes for rheumatic attacks. He also holds that the high arterial tension at the end of an attack is an indication of an excessive proportion of uric acid in the blood, and that, therefore, any cause that increases the acidity at that time tends to bring on a reprecipitation of the acid and a relapse.—*Jour. Amer. Med. Assoc.*

OFFICIAL REPORT OF THE RESULTS OF KOCH'S TREATMENT.

The official report on the results of Koch's treatment in Prussian hospitals has been published in *Klinisches Jahrbuch*, in which it is stated that out of a total number of 1,061 patients treated for tuberculosis of internal organs 13 were cured, 194 improved, 171 substantially improved, 589 unimproved, and 46 died. In external tuberculosis (lupus, scrofula, tubercular joints, etc.) 708 cases were treated; of these 15 were cured, 237 improved, 148 substantially improved, 298 unimproved, and 9 died.

We must confess that this report, which seems to have been made in all candor, is not at all encouraging. Under our old methods of treatment we can obtain some cures and many improvements. The new method does not seem to have accomplished very much more.—*Atlanta Med. Surg. Jour.*

THE THERAPEUTIC VALUE OF VINEGAR

In speaking of the therapeutic value of vinegar, Dr. S. J. Bumstead, of Decatur, Ill., says:

"I trust that a sneer will not curl the lip of him who first glances at the title of this article. But I must admit that the remedy is dreadfully common-place for these days of advanced therapeutics, yet if the reader will but control his prejudice for a few moments, while I point out a few uses for this remedy to be found in every household, I am sure he will become a convert to my good opinion of it, if he will only give it a trial.

"From time immemorial, vinegar has been used as a domestic remedy for colds and sore throats, usually with molasses or honey, and when there is almost a laryngitis with nearly constant tickling, it serves the purpose admirably, checking the tickling cough, and promoting resolution of the tracheal and pharyngeal inflammation.

"But its greatest value, in my opinion, is in cases of catarrhal croup, membranous croup and diphtheritic croup. Here I use it in the form of steam vapor, and although I usually give what I consider as suitable internal medication at the same time, were I confined to the use of but one alone, I think I would in most instances choose the vinegar vapor. The most convenient method of administering it is by placing the vinegar—if not too strong, using it undiluted—in an ordinary bread-pan, to be found in every house. Then, by heating flat-irons or bricks in the stove and placing them in this pan, a great cloud of steam is generated. In this way the whole

room can soon be filled and the little sufferer draws it into his larynx and bronchial tubes with every breath he takes.

"The only difficulty I find in its use is to impress the nurses with the importance of maintaining the steam constantly. There is a disposition on the part of the attendants to keep up the steaming in a half-hearted manner. Of course, this steam is irritating to the bronchi of those who are well, but they can stand it during an emergency. With a severe case of membranous croup I have maintained the steam in the room to such a degree that it would be impossible to distinguish a person across the room. The advantage of this method of treatment over the use of any spray with an atomizer is that its operation is uninterrupted. I have seen a number of desperate cases of croup yield to this treatment, after tracheotomy seemed to present the only hope. So firmly convinced am I of its great value that I believe intubation and tracheotomy would only occasionally be necessary if it is faithfully carried out.

"A few years ago I noticed in one of our medical journals a report of some French physicians upon the virtues of acetic acid. They claimed for it germicidal properties about equal in value to that of carbolic acid. A word to the unprejudiced physician is sufficient."—*North Amer. Press.*

CAMPHORIC ACID.

Dr. H. A. Hare, writes: A man, aged thirty-five, was brought into the Hospital in the early part of January suffering from advanced phthisis with a large cavity at the left apex and with numerous smaller cavities in both lungs. There was a good deal of expectoration of purulent matter and a loose, racking cough, rapidly progressing emaciation, with that peculiar flattening of the wrist, which we so often see, so that the forearms looked like laths, and with such persistent and aggravated night-sweats that the occurrence of each sweat could be seen to increase very markedly his debility and asthenia. So severe was the effect of the sweats that I could always tell on entering the ward whether he had one the night before, and on one or two occasions I was shocked to notice what terrible changes had taken place during the past twenty-four hours. All the anti-sodoric remedies which I could think of were employed, without any avail or with only a slight decrease in the quantity of the sweat. Finally, in despair, I turned to camphoric acid and ordered that

twenty grains of the drug should be administered, stirred up in a little milk or placed upon the tongue and washed down with water one hour before the time at which the sweat generally came on, namely, at one o'clock in the morning. To make a long story short, I can only add that during the remaining four weeks the drug absolutely controlled all sweating, although it was only given once in every twenty-four or forty-eight hours—thereby greatly increasing the patient's comfort and undoubtedly prolonged his life. It is also worthy of remark that this drug did not seem to decrease the other secretions, such as the saliva, or to cause the uncomfortable drying of the throat and feverishness of the skin so characteristic of full doses of belladonna.

The second case was that of a woman, aged twenty-five, suffering from pulmonary phthisis of a more chronic form than that of the case which, I just detailed. In this case also the sweats were very annoying, producing insomnia and loss of strength, although they did not seem to be productive of as much debility as in the case of the man. In this instance, also, camphoric acid in the dose of twenty grains produced a most pleasing effect, completely controlling the sweating. I may also add that I have employed the drug in cases of nervous exhaustion and general debility accompanied with excessive sweating, with considerable success.

When we consider that the dose of twenty grains of camphoric acid is only a third of what may be given in cases where this dose fails, namely, sixty grains, it becomes evident that the drug requires a more general trial by the profession, and that it will probably take a prominent place in the list of our materia medica. It is absolutely devoid of taste, insoluble in water, and comes in small micaceous crystals, which are soluble in alcohol. It does not produce the gastric irritation and burning produced by camphor, and in none of the cases in which I have employed it has it ever occasioned any distress or untoward symptoms.—*Med. News.*

ARISTOL IN DISEASES OF THE EYE.

Dr. James Wallace, in the *Univ. Med. Magazine*, writes: This drug has been for some time before the medical profession as an application to wounds, ulcers and other conditions in which iodoform has proved of value. In its physical characteristics it is superior to iodoform by its greater lightness and finer state of pulverization. In its application to the eye these qualities are of

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much importance, as the mechanical irritation of small particles not sufficiently pulverized often exceeds the alterative effect which we wish to obtain. Apart from this, aristol seems to excite much less irritation than iodoform, even when finely powdered, and can be used with much greater freedom without exciting as much reaction. The faint odor which it possesses is another point greatly in its favor, especially when used around the face.

The class of cases in which it shows its effects most markedly comprises follicular inflammation of conjunctiva, phlyctenular disease of the cornea and conjunctiva, marginal blepharitis, ulcers and after-enucleation of the eye-ball as a desiccant. In epithelioma of the eyelids, in my experience, it lessens the discharge from the ulcerating surface, but exerts no further action on the progress of the disease. In a case of lachrymal abscess, resulting in a large, sloughing ulcer, one centimetre in diameter, one week's treatment by aristol sufficed to close it entirely. In a case of enucleation of the eye-ball occurring in the practice of my colleague, Dr. de Schweinitz, aristol was dusted in the socket immediately after the operation; on opening the lids on the second day no discharge was visible, the aristol had collected in a little heap around the conjunctival opening, and on lifting this out, the centre of the aristol was found to be quite dry.

The rapidity with which phlyctenular diseases yield to its application is very satisfactory, and as its use causes very slight irritation, there is no pain attached to its employment. The largest field for its employment is probably here. As we often desire some preparation of iodine to be exhibited internally we avoid the risk of using calomel, which is free from odor, but is liable to produce sloughing of the conjunctiva when dusted into the eye while the patient is taking an iodide, and the unpleasant odor of iodoform, which is intolerable to many persons, by employing aristol, which agrees with iodine compounds and is free from any noticeable odor.

In papillary trachoma it seemed only to aggravate the symptoms, and no beneficial results appeared to follow its use, but, on the contrary, the photophobia, lachrymation and corneal opacities increased; this appeared to me to be due to the withholding of the proper treatment more than to any positively injurious influence of the aristol. In follicular trachoma its effect is very decided.

MEDICINE.

DISEASE OF THE CAUDA EQUINA.

Bechterew has recently met with a case in which he has diagnosed affection of the conus medullaris and the cauda equina. An abstract is given in the *Neurologisches Centralblatt*, No. 5, 1891. For some weeks before the patient came under observation he had suffered from a gradually increasing weakness in the legs, together with urinary trouble and weakness. On examination there was loss of sensibility with regard to tactile and also to painful impressions on the penis, scrotum, perineum, and gluteal region. There was also similar impairment on the inner and posterior aspects of the thighs. There was much muscular weakness, so that the patient could not walk without the help of a stick. The knee-jerk was normal, and of the superficial reflexes none were lost with the exception of the gluteal. There were incontinence of urine and obstinate constipation, although at times there was involuntary defecation. There was marked tenderness over the sacrum. The author concludes that the case is one of lesion of the conus medullaris and cauda equina, and draws attention to the correspondence of the clinical symptoms with those produced experimentally in dogs by section of the cauda equina.—*Lancet*.

ARSENICAL NEURITIS.

A good deal of attention has lately been given in America to the frequency of poisoning by arsenic, and it has been pointed out that a very much larger number of cases of this kind occur than is generally supposed. Among children especially, it is contended, the proportion of sufferers in this connection is considerable, wall papers colored with arsenical paints being the source of the poison in their cases as bearing on this matter. A remarkable statement was made at a recent meeting of the Boston Society for Medical Improvement by Dr. Putnam, who said that as the result of his own observations, he found traces of arsenic in thirty per cent. of the urines which he had examined with a view to ascertaining whether or not it was present in them. Eighty different samples were tested, and none of the patients exhibited any typical symptoms of poisoning by arsenic. The conclusion, of course, is, that a very large proportion of the general public, inasmuch as all are more or less exposed at some time or other to arsenical emanations, is un-

consciously infected. The occurrence of peripheral neuritis and paralysis as a result of this form of poisoning is established by the narration of a considerable number of instances in which it has been observed, and during the discussion referred to above, several such histories were detailed. Dr. F. C. Shattock described four cases of the kind as coming within his own experience, one of them being a choreic young woman who had been treated with large doses of arsenic, and in whom extensive arsenical neuritis and paralysis resulted. Another of these cases was that of a woman who had been supposed to suffer from rheumatism for years, but as Dr. Shattock suspected it might be due to arsenical poison, he examined the urine with the result that it was found to be largely impregnated with the metal. Testimony of a similar kind was offered by other observers, and there seems to be a very general opinion that the conclusions are fully justified facts. Dr. Putnam arrives at the following deductions in this connection:—(1) That chronic arsenic poisoning is manifested under four or five distinct forms, accordingly as the mucous membranes, the skin, the nerves, or the blood become primarily affected by the poison. (2) That one member of a household may alone be subject to the influence of the poison, others in the same dwelling remaining coincidentally unaffected by it. (3) That symptoms may long outlast exposure. (4) That susceptibility to minute doses of the drug may follow poisoning. (5) That children, as a rule, can endure comparatively large quantities of arsenic, and that neuritis, though less frequent in them, does occasionally occur. (6) That elimination of the poison takes place less rapidly than has been commonly assumed.—*Med. Press.*

GRAVES'S DISEASE.

Dr. Hingston Fox read a paper before the West Kent Medico-Chirurgical Society on Graves's disease, especially with reference to cardiac condition. After speaking of the four cardinal symptoms, rapid heart, tremor, goitre and exophthalmos, any one or two of which may be absent in an undeveloped case, he dwelt on the mental condition found in severe cases. The emotional centers seem to be in unstable equilibrium, disturbed by slight influences, a condition allied to hysteria and to the effects of chronic alcoholism in woman about the climacteric. Muscular weakness and impaired nutrition, with neuralgia and the well-known eye symptoms were noted.

Severe gastric crises had attended one case, the patient nearly dying from the vomiting, diarrhoea, etc., which appeared to be the effects of "bowel hurry." Dr. H. W. G. Mackenzie's theory of the pathology of the disease was adopted, the symptom being regarded as an expression of a permanent condition of the emotional nervous centers, set up in the first instance by terror or fright. Darwin's graphic description of the effects of sudden fear upon animals was alluded to, the thyroid enlargement being the only important symptom of Graves's disease which is there unrepresented. The fright may have been sudden, or a repetition of small shocks. Instances were quoted in illustration of this. This theory brings us, of course, only one step nearer to the true pathology, as regards the heart, beyond a hæmic murmur and eventually dilatation, there is not usually any sign of disorder except the rapid and irregular action. Some cases show tachycardia, others mainly irregularity; in some the condition is continuous, in others paroxysmal. The graphic record of one severe case in a lady, aged 49 years, was shown, extending over eight months. Here attacks of irregular and rapid heart action occurred at intervals of a few days or a week and lasting 24 hours or so. For treatment numerous remedies have been advocated. The author would lay stress on (1) moral and hygienic care in its widest sense; (2) improvement of nutrition, much milk, cod-liver oil, iron; (3) of drugs, balladonna in mild and early cases, iodides in later stages, pushed fearlessly to large doses, bromides in some cases; (4) locally the weak continuous current, following Dr. Samson in persevering long with its use, it should be applied to the thyroid with a large plate; Lister's cold coil also gives some promise; (5) for tracheal obstruction, tracheotomy, incision of capsule of tumour, or compression laterally in some cases, inhalation of chloroform, or lastly, division of the isthmus offers the best hope of relief.

SURGERY.

PROGRESS IN TRANSPLANTATION.

Dr. R. Haug, assistant at the Royal Surgical University-Polyclinic of Munich, has published an "Experimental surgico-histological essay" in which he demonstrates that the shell-membrane of a hen's egg is highly applicable to transplantation. On the strength of thorough experimental researches he makes the following statements:

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The fresh shell-membrane of a hen's egg is perfectly capable of organization and therefore eminently fit for transplantation. It is only that side of the membrane which is turned towards the calcareous shell of the egg which can be used for the purpose of transplantation. It is not a mere agglutination that takes place in the case, though immigration of leucocytes from the neighboring tissues agglutination is gradually transformed into perfect assimilation. The intimate fusion of both tissues attains its climax in the appearance of an extensive vascularization. The latter causes the shell membrane to lose its specific properties and to be progressively transformed into connective tissue. For this reason the membrane, as above stated, is eminently qualified to be used in all classes of granulating wounds, especially also for definite occlusion of tympanic canal.

A successful transplantation of a dog's skin on an extensive wound caused by burning has been performed by Dr. Alexander Miles, in England. This case presents a two-fold interest; first, on account of the great frequency of such accidents, and then on account of the unusual therapeutic method made use of.

The left leg of a 10-year-old boy had been scalded up to the knee by accidental immersion in boiling hot, liquid cow food, and although he had succeeded in disengaging the leg immediately, it was found that the cutis had been loosened from the middle of the patella down to the articulation of the foot, the foot itself having been protected by the leather shoe. He was at first treated according to empirical methods and it was only after four weeks that a physician was called in. When the patient was admitted to the hospital, the whole lower part of the left leg was deprived of its cutis, with the exception of a small spot on the anterior side of the tibia, and the surface of ulceration was in a large proportion covered with healthy granulations, only a few necrotic fragments having remained attached between them. The latter yielded soon to the application of boracic acid compresses and after their gradual expulsion a fortnight later the whole surface of ulceration presented a healthy field of granulation, without any vestige of cicatrization. The enormous extent of the wound precluded all possibility of covering it with human skin and it was determined to use the skin of some animal. Miles selected a young, smooth-skinned dog for the operation. It was a week old and its color was black and white. After having killed it

with chloroform, the whole ventral and crural portion of the skin was excised and a patch was formed consisting of the whole cutaneous tissue with the exception of the adipose layer. In the mean time the leg had been carefully cleaned and all blood had been removed from the granulations. The excised skin was divided into a number of strips, 4 inches long and $\frac{1}{2}$ inch wide, and firmly pressed into the surface of ulceration, while smaller fragments of 1 square inch were used in filling up the gaps between the larger pieces. To a somewhat larger spot on the inside of the knee a piece of smooth skin from the tail of the animal was applied. Then, the whole was covered with a protective bandage, over which gauze imbibed with diluted boracic acid was added, and humidity was further maintained by a layer of gum tissue, over which finally a thick layer of sublimate-wadding and a firm bandage were applied. On the third day the bandage was renewed for the first time and, with the exception of a small fragment which was ulcerating and was removed, all other pieces were found to be firmly attached and the cicatrization process beginning, as well as the edge of the large ulceration as in the center. The healing process progressed rapidly, although some particles of the large strips were ulcerating; all the smaller fragments were well attached. After 3 weeks the spots remaining bare were filled up with human skin (taken from a boy) and all were cicatrized in a short time. Six weeks after beginning of the treatment the ulceration was completely healed, but the patient was kept in bed for another fortnight and then he was allowed gradually to set the extremity in motion. When the boy was seen again, 7 months later, there was absolutely no contraction to be noticed in the cicatrice with the only exception of a very slight contraction where the caudal skin had been implanted. The color of the whole skin was uniform and very similar to the normal color, nor was there any hair or secretion to be seen; the sense of tacton was not weaker than in the right leg and the temperature was the same.

In a case as the one related success depends principally on three elements: 1. The general condition of the patient; 2. the character of the process of ulceration; 3. the means employed for the purpose of accelerating the healing. In the case above stated the only favorable point in the general condition of the patient was his age. His general condition was very low the favorable result was mainly due to the method

of treatment. Although it could not be said that just a dog's skin is better approprial for transplantation than the skin of other animals, it presents at least the advantage of being always on hand and of furnishing a sufficient material for most cases. A most important element is the age of the dog. During the first days after birth the animal grows very rapidly and by transplanting a large portion of young tissue, endowed with an energetic growing force it becomes possible to cover rapidly the whole surface of ulceration, this preventing contractions which always makes their appearance after extensive burnings, if they heal without artificial intervention.—*Deutsche Medizinische Zeitung.*

CATHETERISMUS POSTERIOR.

Under this title Dr. Goldmann (*Beitr. z. klin. Chir.*, 1891, p. 460) gives an account of a case in which no instrument could be passed up the penis into the bladder, but in which, after a suprapubic opening had been made into the bladder, a catheter was passed down into the perineum from the bladder and the stricture excised, with an excellent result. The man had suffered some years previously from gonorrhœa, and though he had had trouble with his stricture from time to time, had not suffered from permanent stoppage until some few months before he came under Dr. Goldmann's care. Another surgeon had performed suprapubic puncture, and so relieved for a time the urgent symptoms, but a severe cystitis ensued after a while, causing great pain both in the perineum and in the lower part of the abdomen, as well as some erysipelatous kind of swelling of the lower abdominal wall. Under these circumstances, as soon as he came into Hospital a fairly stiff elastic catheter was introduced through the abdominal puncture, which was by this time large enough to admit the little finger. It was, after some little trouble, manipulated along the prostatic urethra as far as the stricture, and another instrument was passed down along the urethra to meet it. The intervening stricture was then excised, and the cut ends of the urethra united by catgut. The swelling above the pubes speedily disappeared, and in about three weeks the patient was able to leave the Hospital. The plan, as the author remarks, is no new one, but instances in which it is applicable are but few. The manoeuvre is somewhat aided by pulling on the penis, and if possible hooking up the anterior wall of the bladder, as by this means the prostatic opening of the urethra is rendered more funnel-shaped, and is con-

sequently more easily traversed by the catheter. References are given to some analogous cases, together with a full account of the different conditions to which this method is applicable, as well as the reasons which render it more likely to be attended with success now than formerly.—*Brit. Med. Jour.*

A MODIFIED SUTURE FOR INTESTINAL ANASTOMOSIS.

Sachs (*Centralblatt für Chir.*, No. 39, 1890, p. 737,) after referring to the various methods now in use, explains his modification of Senn's bone-plate method. Instead of two plates he uses one piece of bone, which he compares to a cuff-button with a hole through it. It more nearly resembles a pulley wheel.

At the desired place for anastomosis the lateral surfaces of the intestinal loops are approximated by suturing serous membrane to serous membrane. A longitudinal incision is then made into each section of gut parallel to the line of suture. The bone button is then slipped in so that the line of suture with the two internal incised edges fits in the groove. The outside edges will fall into place in the other side of the groove, and a few stitches approximating serous surfaces will be found sufficient to retain the parts firmly.

The advantages claimed for this method are:

1. The intestinal lumen is not kept open long.
2. The line of incision is protected from infection by the internal ring—which also prevents closing of the incision.
3. Compression of the intestinal edges is prevented.
4. The sutures do not penetrate the whole thickness of the intestine.

The author has only used this method upon guinea-pigs. The buttons are made of decalcified beef-bone.—*Amer. Jour. Med. Science.*

GYNÆCOLOGY.

WHAT DISEASES SHOULD BE NOTIFIED AS PUERPERAL FEVER?

There can be no doubt that considerable difficulty is often experienced in deciding whether a particular case of *post-partum* illness should or should not be regarded as "puerperal fever," and notified as such to the sanitary authority. Most practitioners would rather not call an illness "puerperal fever" if they can conscientiously believe that another name is appropriate to it. On

the other such a case the friends think she is herself competent.

One of popular opinion must feel a sense of justice. In theories accepted views, not but of the young, and Irish accepted ment they would misunderstand it an ab-

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the other hand, if they omit to report as such a case which some one else, believed by the friends to possess superior knowledge, thinks should be given that name, they lay themselves open to the charge either of incompetence or lack of frankness.

One of the conditions of a system of popular government like ours is that legislation must be in accordance with the general feeling and opinion of the time. If in advance of the time it is sure to fail in its object. In sanitary legislation the medical theories acted on must be those generally accepted; they must be in harmony with the views, not of the most recent investigators, but of the great bulk of doctors, old and young, town and country, English, Scotch, and Irish. A law based on theories not yet accepted by the bulk of those on whose judgment the carrying out of the law depends would raise an amount of opposition and misunderstanding that would go far to make it an absolute failure.

We imagine that some such reasons as the above influenced those by whose advice the term "puerperal fever" was inserted into the "Notification of Infectious Diseases Act" (1889). Just as "continued fever" was a sufficient diagnosis before typhus and typhoid fever had been differentiated, so until the last twenty years, or even more recently, more was known of puerperal fever than that it was a severe febrile disease affecting lying-in-women. Even now no other definition can be given to it. It used to be thought that all such cases were essentially alike, although they might differ in detail. One distinguished American obstetrician, we believe, still holds the view that there is a specific febrile disease affecting lying-in-women and no other persons. It was thought that puerperal fever was often epidemic. Such views as these were acted on by the late Dr. Farr, when the term "metria" was introduced as the equivalent of puerperal fever, and we presume this is the view tacitly accepted in the Act we have referred to.

The object of the Act is to enable, in the interest of the public, such precautions to be taken as shall prevent infectious disease being communicated by a patient to other persons; and abundant experience has shown that in most of the diseases named in the Act prompt action in isolation, disinfection, etc., is successful in doing this. In others the mode of propagation is so far obscure that the inquiries which notification may set going must be productive of increase in our knowledge, and therefore our power of pre-

vention. No similar statements can be made about any of the diseases comprehended under the vague term "puerperal fever." They are not epidemic. This was proved in the most conclusive way by the late Dr. Matthews Duncan. The pupils of that eminent man can remember how, with grim humor, he used to say that when a great lady died in her confinement all the doctors said there was an epidemic; but if a poor woman in the Edinburgh Cowgate died after delivery no one thought of an epidemic then. "Puerperal fever" includes septicaemia, septic intoxication (the *sapraemia* of Matthews Duncan), pyaemia, phlegmonous inflammation of cellular tissue (the "*erysipelas malignum internum*" of Virchow), wound diphtheria or gangrene, as well as the less formidable conditions of endometritis, cellulitis, perimetritis, and fever from slight transient causes. All these are wound diseases; they are spread by want of cleanliness. If isolation be required it is isolation of those attendant on the patient, not of the patient. Cases must be very exceptional in which any good can come of the interference of the local sanitary officer; and in the few instances—likely to become fewer and fewer—in which investigation might do good public attention would be certain to be drawn to the matter, even were there no notification. Every argument for reporting deaths after childbirth applies equally to cases of febrile illness following surgical operations.

It is unfortunate that so vague a term as "puerperal fever" should have been thus legally stereotyped. But as it is so, it appears to us that the best way in which medical men can act harmoniously together for the public good—and no profession has ever been more ready to sacrifice its private interests for the public benefit—is in every case of febrile illness after delivery, not clearly arising from some cause quite independent of the process of labor, either to report the case or else to consult the medical officer of health for the district to ascertain from him in what class of cases he hopes for good results from their notification to him and to act in accordance with his advice. There is now abundant proof that such cases are very rare in the experience of those who carefully observe antiseptic precautions in their practice, and if now and then a doctor, by styling a case puerperal fever, for which he might have found a less formidable appellation, should incur the undeserved censure of some hastily-judging persons, his doing so will increase for him

the respect of others, who will understand and appreciate his desire to be perfectly candid with those who trust him and to do his duty to the public.—*British Med. Journal*, May 23, 1891.

ENDO-UTERINE THERAPEUTICS.

Dr. More Madden recently read a paper on this subject before the *Roy. Acad. Med. Ireland*. With regard to the methods of modern uterine treatment and the conditions by which this is called for, the author's observations are founded on a clinical experience extending over many years, and embracing upwards of 10,000 gynecological cases treated in his wards or in the extern department of the Mater Misericordiae Hospital, Dublin. Of the cases admitted into those wards during the last fifteen years, endo-uterine treatment was found necessary in 35 per cent. The two essential points in all such treatment are, first, that the orifice and cavity of the uterus, if not already sufficiently dilated, should be mechanically expanded; and, secondly, that whatever application is resorted to should be brought into direct contact with the diseased endometrium. For the first purpose the slow, painful, and hazardous methods of dilatation by sponge or laminaria tents have been long abandoned by Dr. More Madden, who employs in their stead, the rapid cervical dilator which Messrs. Arnold have brought out in accordance with his suggestion, and which he finds more effective and quicker in its action than Hegar's or other similar dilators. The second object is especially necessary as a preliminary to endo-uterine treatment in cases of congestive hypertrophy and chronic subinvolution, in which the lining membrane of the uterus is commonly overlaid by an impervious pseudo-membranous albuminoid neoplasm evolved from the proliferating cilia of the diseased surface. Or else the endometrium, in many cases, is so thickly bathed in the tenacious morbid secretion therefrom, as effectually to protect the underlining tissues from the action of any remedial agent introduced into the uterine cavity until that pseudo-membrane and secretion are removed by the curette. For these objects Dr. More Madden recommends, first, the use of Duke's cervical curette to cleanse out the entrance to the womb; and, secondly, the employment of his own adjustable uterine curette, by which the endometrium may be thoroughly denuded, and at the same time by the hæmorrhagic discharge thus occasioned the congestion of the hyper-

æmic and hypertrophied organ may be most effectually relieved. In the treatment of subinvolution the author advocates the introduction, in some instances, of a small tampon saturated in a combination of tannic acid and turpentine, which he terms "tannoterebinth." This acts as an immediate stimulant and astringent on the uterine structures, and in suitable cases is allowed to remain in the cavity from twelve to twenty-four hours, unless sooner expelled from the then generally much contracted uterus. The vaginal glycerine saturated tampon commonly employed in cases of this kind, although unquestionably serviceable in many instances, is messy and troublesome in its use both to patient and practitioner, and hence for some time past Dr. Madden has generally adopted the boric acid, or "dry treatment," recommended recently by Dr. Duke, and which he has found generally satisfactory as a substitute for the older method of treatment. He also strongly deprecates the employment of the ordinary syphon syringe for any endo-uterine purpose, and believes that this should be replaced by an irrigator such as the one he suggested many years ago, and which, having been since appropriated by others, without any acknowledgment, is depicted in the paper of which this is an abstract. The foregoing measures must, however, be supplemented by more active agents in those more serious cases of long standing, fundal, or corporeal endometritis and subinvolution in which the disintegrated and endo-uterine mucous membrane becomes the seat of various pathological changes, extending to the submucous structures and uticular glands, and often associated with those so-called fungosities resembling papillary epithelioma, which, if unchecked, may ultimately degenerate into that condition. In such cases it is that the cautery, actual or potential—the first in the form of igni-puncture, and the latter in the shape of the stronger caustics, acid, nitrate of mercury, fuming nitric acid, or chromic acid, etc.—may be justifiably resorted to in endo-uterine treatment. In conclusion, Dr. More Madden briefly details the result of his clinical experience of these various applications, the circumstances that indicate their use, the dangers that may attend their abuse, and the methods of their employment.

—*Lancet*.

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Vaseline..... 3 iss.
M. Sig. Anoint the affected parts once daily.

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OBSTETRICS.

AN IMPROVED METHOD OF MANAGING THE CORD IN PROLAPSED FUNIS.

On the 3rd of March, 1890, Dr. L. T. Emery was called to attend Mrs. G. in confinement. His patient was of medium size, well nourished and a fairly vigorous woman, thirty-two years of age. She had been attended in her previous labors by Dr. Bodkin, of Brooklyn, and all three were described as having been difficult and requiring instrumental delivery.

Upon examination the cervix was found to be well dilated and the bag of waters intact (though rupturing very soon); the funis was prolapsed to quite an extent, and the head presented at and was partially engaged in the superior strait, the position being right occipito-anterior.

The pelvis was narrow—a condition most frequently existing where this accident occurs—and seemed to prevent delivery except with instrumental aid.

The patient was placed in a knee-chest position, which was somewhat exaggerated by the tilting of the mattress, preparatory to returning the cord by Prof. Thomas' method. In attaching the sponge—which had been thoroughly cleansed in boiling water—to the cord, Dr. Emery made use of the following device: A tape, one inch wide and twenty inches long, was bifurcated at each end about eight inches. Three-quarters of an inch from the point of bifurcation of one end, a button-hole slit was made in the broad part of the tape, leaving, something over two inches of broad tape intact.

The sponge was secured by tying the bifurcated ends nearest the button-hole around it, and then drawing one of these through the button-hole and again tying. The bifurcated ends of that part of the tape farthest from the button-hole were then passed around the prolapsed funis, and one end was thrust through the button-hole and the two ends tied securely and further tied around the sponge.

It is claimed for this method that the broad bearing of the tape lessens the danger of destroying the circulation between the mother and child, and that the sponge is held closely adjacent to the cord without constricting the latter nor slipping from either.

Passing a loopy of the narrow part of the tape into the eye of a gum elastic catheter and securing by means of the stylet, and

pressing forward or upward, with the catheter in my left hand and aiding and guiding the sponge with my right, the cord was passed one side of the sacral prominence, beyond the head of the child and into the uterine cavity.

Still keeping the patient in the same position he proceeded to apply the forceps. This was accomplished by reversing the procedure usual when the patient lies in a dorsal position, though still preserving the relative position of the forceps to the head of the child and the pelvis of the patient, the upper blade being passed into position first and the lower blade last. Traction was then made and the head engaged in the superior strait, when the patient was laid on her side and the delivery accomplished of a living child as in a case of ordinary forceps application.

The uterus was douched with a solution of biniodide of mercury, and the mother recovered without the occurrence of fever or any other untoward event, as the result of the treatment she had received.

CHLOROFORM IN OBSTETRICS.

Dr. J. F. Baldwin of Columbus, Ohio, in a paper read before the Ohio State Medical Society, entered a plea for the more frequent use of chloroform in obstetrics.

His obstetrical triad is as follows:

During the first stage of labor, morphia.

During the second stage of labor, chloroform.

During the third stage of labor, nothing.

Summary.—Chloroform relieves pain.

It shortens labor, usually.

It prevents shock.

It prevents nervous and physical exhaustion.

It reduces the liability to rupture of cervix and perineum.

It does not conduce, in any material degree, to post partum hæmorrhage.

It does not affect the fœtus.

It is absolutely safe when properly administered.

Contraindications.—1. Such conditions of labor as lead the obstetrician to believe that he may, at some supreme moment, require all the woman's voluntary efforts to assist him. Such conditions are very rare. 2. Fatty degeneration of the heart; though, if we accept the conclusions of the Hyderabad Commission, even this may not be a contraindication; and the disease is practically never diagnosed except post mortem.—

Memph. Med. Month.

CASE OF SUDDEN AND UNEXPECTED DELIVERY IN THE ERECT POSTURE.

There being only a limited number of cases of sudden and unexpected delivery in the erect posture on record the following case is perhaps worthy of mention:

S. D., aged 21, who had previously, after a lingering labor, given birth to one child, was recently visiting a friend, when she felt a sensation of giddiness. She therefore left and started on her way home. Having walked fifty yards a sudden pain in the abdomen was experienced; the pain was so acute that she retired to a neighboring out-house. She had no sooner arrived there than she gave birth to a full term male child. The child fell head foremost on to the stone floor. The fall was broken by the cord, the cord was ruptured, and no hæmorrhage occurred; the child sustained no injury, not even a bruise being apparent, and is still alive (two months after the occurrence). The mother walked back to to her friend's house, and has made a good recovery.

There had been a miscalculation of two months in this case of the probable date of parturition, and the mother had no idea of the cause of the pain until the child fell from her.

DR. E. HUGH SNELL, in *Brit. Med. Jour.*

GIANT FÆTUS; CÆSAREAN SECTION.

Dr. R. Neumer (*Centralbl. f. Gynäk.*, April 25th, 1891) describes a case where a woman, aged 40, bore a giant fœtus. She had already given birth to eleven children, and it appeared that labor occurred a month after term. The abdomen was unusually large, and as the labor made no progress turning was attempted. The child was found to be of enormous size, and could not be extracted, its pelvis sticking fast in the maternal pelvis. An attempt to disarticulate the leg, as a preliminary to evisceration, failed, as the hip could not be reached. The mother being in a critical condition, Cæsarean section was performed, but she sank shortly after the extraction of the child. The child (together with the blood which it had lost in great quantity through the attempt at amputation, so that it was almost bloodless when extracted) weighed nearly 24 pounds.—*Brit. Med. Jour.*

THE TEMPERATURE AFTER LABOR AND SO-CALLED LATE INFECTION.

Stapfer (*L'Union Medicale*, Aug. 2 and 14, 1890) believes that the most valuable index

of a woman's condition in childbed is the daily morning and evening record of the temperature. He has noted that a temperature persisting slightly above normal, with a trifling evening rise, is often the precursor of the so-called late infection. A temperature of 100° or 101° may be present on the evening of the first day, due to the fatigue of labor; forty-eight hours later, as the result of the milk secretion. At any time before the fifth day it may occur from faecal intoxication, when the bowels have not been evacuated. This elevation, however, is transient. It is the persistence of a slight elevation to which he calls especial attention, and he believes that in such cases the absorbed poison may be so attenuated as to produce no other symptom for a variable length of time. In one of his cases very slight fever, continuing during three weeks, was the only morbid phenomenon of septic infection.

He believes that the thermometer can predict the occurrence of so-called infection, such as pelvic inflammation and abscess, phlegmasia, pulmonary and visceral thromboses, cutaneous eruptions, which may occur from the seventh or twelfth day to the fifth or sixth week. When any of these complications are to occur, the temperature ranges between 99° and 101° up to the time of their occurrence, with, perhaps, an occasional temporary fall to normal. Many patients are discharged with this amount of fever unnoticed, who later return to hospital with one of the above complications fully developed. He cites several such cases, and believes it demonstrated that the poison (*streptococcus pyrogenes*) is either encysted and localized, or spreads by the blood giving rise to complications whose nature and gravity depend upon the number and virulence of the microbe and its secretions and the receptivity of the soil. He is convinced that in such cases the three weeks of apparent apyrexia is a veritable period of incubation, revealable by the thermometer, whose value, therefore, is exceedingly great in conditions apparently normal and physiological. In a case with intestinal paresis and considerable distension, severe pain in iliac fossa and over the uterus, anorexia and disappearance of milk secretion, he predicted that the patient was not septic and gave a favorable, and afterward justified prognostic, because the temperature during a week had remained between 97.7° and 99.1°.

Barbers will soon be compelled to use antiseptic precautions.

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PÆDIATRICS.

CLOUSTON—THE NEUROSES OF DEVELOPMENT.

Traumatism is assigned by most authors as a cause for idiocy and congenital imbecility. Parents are prone to look for some accident as to the cause for such conditions, resolutely shutting their eyes to manifest hereditary weakness. While the author makes allowance for such sources of error, he believes that there are left certain cases where traumatism must be assigned as the exciting cause of the arrest of brain development. This is intelligible enough when there is a gross lesion of the brain, as a clot causing pressure. It is not as clear, but still must be accepted as a fact, that sometimes a fall or a blow is followed by a change in the development of certain brain functions. Traumatic idiocy is in such cases not as marked either in mental impairment or in physical expression.

Rickets, night-terrors, the febrile delirium of children at temperatures ranging from 99° to 101°, infantile eclampsia, and the hysterical affections of childhood are all classed by the author as neuroses incidental to childhood from birth to seven years. They all occur in children of neurotic heredity far more frequently than in other children. They are referable to weakness of inhibitory function and instability in the brain cortex at an era when the organ is rapidly growing and the convulsions are deepening and expanding in even greater proportion than the rest of the brain. Rickets is clearly a trophic neurosis probably due to want of sunlight sufficient to give stimulus to the central trophic nervous centres which innervate the bones and perhaps other tissues. But these exciting causes of want of light and bad city conditions of life will not, as a rule, produce rickets in the children of healthy, country-born parents. That the brain cortex is affected is evident from their common neurotic accompaniments, retardation of growth, and a tendency to precocious and unhealthy mental advancement which stops short of full mental growth.

The author agrees with Jenner and Henoch in attributing the so-called convulsions of teething far more to rickets than to dentition. The first motor sign of the instability of any brain is a tendency to convulsions during the first dentition. Many cases of developmental epilepsy will be found to have had convulsions during dentition. The same kind of unstable brain will become de-

lirious at night even with very low febrile temperatures. Such children will take convulsions at slight attacks of indigestion.

Night-terrors, the author believes, is an affection that is really psychical, and may be considered equivalent to a convulsion occurring in the mental areas during sleep.—*Edinburgh Medical Journal*, March, April, May, 1891.

INFANTILE SPLENIC ANÆMIA.

The following are Somma's conclusions:

1. Infantile splenic anæmia, or splenic pseudo-leukæmia is a common disease of childhood, more common than has usually been supposed. Its origin may date from the very beginning of life.

2. Its introduction into modern pathology is largely due to the investigations of Cardarelli and Luigi Somma.

3. It is characterized by the well-known form of progressive grave anæmia, associated with chronic hypertrophy of the spleen which, with its special characters, has no relation with other morbid conditions.

4. Clinically it is manifested by a complex train of pathognomonic and accidental phenomena. The first or necessary ones are unfailing in every nosographic form of the disease, the second may be present but are not always clearly distinguishable.

5. In its circle of evolution three periods are usually to be observed, being periods of beginning, development, and cachexia.

6. There are three principal forms of the disease, the chronic febrile form, the chronic afebrile form, and the chronic form with recurring attacks of fever.

7. The true nature of the process is not yet clearly understood, but from such investigations as have been made it is supposed to be due to a micro-organism which is introduced into the system and finds its medium of development within the spleen. Having passed into the circulation of this organ, it determines the many anatomical and functional changes in the organ which mark the clinical phenomena of the disease.

8. It has a chronic cause which varies from eight months to three years, and there are also cases which continue when adult life has been reached.

9. The disease may terminate in three ways,—in death, which is the most frequent way; in a prolonged chronic state, which continues into adult life; and in complete cure.

10. The prognosis should be a most guarded one, and one should aim chiefly to

to modify the symptoms. The propriety of splenectomy is not yet decided upon. Such a grave operation is of course to be avoided if possible.

NUCLEATED RED BLOOD-CORPUSCLES IN THE ANÆMIA OF CHILDREN.

Dr. John Loos, of the Pædiatric Clinic of Prof. Escherich in Graz, reports as follows to the *Wien. Klin. Wochenschr.* No. 2. 1891. The author found the nucleated red corpuscle in thirty-one cases during life. The cases were for the most part of children under two years of age, only four ranging between two and thirteen years. In one instance it was a child with trismus; in another a boy of five years afflicted with pulmonary tuberculosis (the only case of tuberculosis in which this corpuscle was found.) Five other cases were children suffering from chlorosis, syphilis, or purpura. A great majority of the cases presented a symptomatology which clearly corresponded to the splenic anæmia of Henoch and the infantile pseudo-leucæmic anæmia of Jaksch. The children are extremely pale, their skins glossy, but they are fairly nourished. The peripheral lymph nodes of the axilla, the neck, the inguinal region are greatly enlarged; and the internal glands are enlarged and soft, not indurated. A splenic tumor was universally present. The bones were rachitic. In addition to the nucleated corpuscles, the blood contained a diminished amount of coloring matter, a reduction of the amount of hæmaglobin, and more or less pronounced leucocytosis.

The character and the etiology of the disease are as yet obscure. The prognosis is absolutely unfavorable. A reduction of the spleen-tumor, as described by Henoch, was not observed in any of Loos' cases. The children, when they did not succumb to the anæmia itself, fell a ready prey to such intercurrent diseases as pneumonia.

HYGIENE.

EPIDEMIC RELATIONS OF DIPHTHERIA IN NORWAY.

Axel Johannessen, of Christiania, reviews the various epidemics of diphtheria which have occurred in Norway, and makes some remarks upon diphtheria and croup. He concludes that the largest part of cases of croup which occur both before and after the great epidemics of diphtheria are of diphtheretic nature.

An interesting point is developed regard-

ing the mode of invasion of the disease and the parts of the country affected. These, in different epidemics, have been to a certain extent the same. Density of population and such means of conveyance as railways and streets do not appear to play any part in the spread of the disease. The coast districts have one-third more cases of diphtheria than the inland districts, and the fishing districts of the coast are the most affected. At Dorschang from 25,000 to 30,000 men collect in 5000 huts, being huddled together under bad hygienic conditions. At Tromsø-Stift diphtheria generally shows the highest number of cases of the disease—as many as 105 per thousand of population. Moreover, statistics also show that those districts whence the fishermen are sent out and return again are invaded by the disease in proportion to the number of fishermen, a condition which is true of other epidemic diseases, especially typhoid fever.

In Norway and Sweden the morbidity in the cities is, on the whole, greater than that of the country; but usually epidemics in cities develop more slowly, and rarely reach an excessive height; whereas, it is much more frequent for an epidemic in the country to rise rapidly to a high ratio between diseases and population. The mortality is absolutely greater in the cities; on the other hand, the percentage of dead of those medically treated in the country districts is considerably higher. This circumstance seems to be due to the fact that throat diphtheria is, in the country, more fatal than in the cities, where, on the other hand, a decidedly greater number of victims is furnished by diphtheria of the larynx.

The great variations in the disease curves are not primarily dependent upon meteorological influences.—*Deutsche med. Wochenschrift*, March 19, 1891.

BARBERS AND CONTAGIOUS DISEASES.

Antisepsis is now the law of the land in Germany, and it is not long since some violation of its rather changeable precepts was punished with imprisonment. The victim in that case was a midwife, but medical men have, we believe, been threatened with similar penalties. Barbers are, in some parts of Germany, subject to strict rules as to the disinfection of their razors, curling irons, etc. That enactments of this kind might with advantage be made general, not only in the Fatherland, but in other countries, is shown by a case recently reported to

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the Berlin Dermatological Society by Dr. Oesterreicher. A man, aged 30, presented himself, with a papulo-squamous eruption, enlargement of the lymphatic glands in the neck and elsewhere, mucous patches on the soft palate and other secondary syphilitic lesions. The patient denied all knowledge of any primary infection, nor did the most minute examination of the genitals reveal any suspicious appearance. On the left side of the face, however, there was an area of cicatricial thickening exactly resembling a healed hard chancre; this, the man stated, was a result of a cut received some time before whilst in the hands of the barber. Dr. Oesterreicher had no doubt that the disease had been inoculated in that way. In 1884, Dr. Löbl, of Vienna, reported a number of cases in which sycosis, herpes tonsurans, and alopecia furfuracea, had been communicated by dirty razors and other implements of the hairdresser's *armamentarium*, and urged the desirability of making it compulsory for these artists always to disinfect their instruments before use.—*Brit. Med. Jour.*

THE IDENTIFICATION AND STAINING OF TUBERCLE BACILLI.

Mr. Baker, High Holborn, London, has had the happy idea of fitting out a small box with all the requisites for the prompt staining and identification of the tubercle bacillus. Although the collapse of Koch's treatment has lessened the interest which this particular microbe excited a few months since, it must always be a great assistance in the diagnosis of doubtful cases to be enabled to subject the sputum to bacteriological investigation. The box, which measures 8 by 6 by 4 inches, contains an adequate supply of fuchsin and methyl blue (the latter for counter staining), with acid solution for decolorising, and balsam for mounting purposes, in addition to a spirit lamp, watch and cover glasses, slides, etc. Full but simple and explicit directions are pasted on the inside of the lid which, in our hands, proved perfectly workable and satisfactory.—*Med. Press.*

MEDICAL CHEMISTRY.

ON THE PRESENCE OF URETHANE IN THE URINE IN BRIGHT'S DISEASE.

In examinations of large quantities of albuminous urine, Dr. Rademaker has always met with a crystalline organic compound that was soluble in water, ether, chloroform,

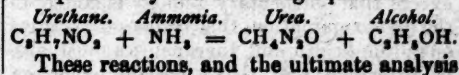
alcohol, and benzol, and almost insoluble in petroleum ether. This organic compound differs from all the constituents of normal urine. This compound can be readily isolated by the following process: Evaporate several litres of albuminous urine to dryness on a water bath, and extract the residue with 98 per cent. alcohol and filter. Allow the alcoholic solution to evaporate at a low temperature. Treat the oily residue with dilute sulphuric acid and extract with ether; allow the ether to evaporate spontaneously. The residue contains urethane in an impure state. Dissolve the residue in distilled water, and filter from the oily matter. Treat the filtrate with carbonate of potash to an alkaline reaction and again extract with ether, the ether allowed to evaporate and the residue placed in an exsiccator over sulphuric acid, when gradually crystals in the form of plates separate. These crystals are dissolved in distilled water, and the solution treated with a solution of subacetate of lead, the excess of lead being removed with carbonate of soda and again extracted with ether. If now this ethereal solution is allowed to evaporate spontaneously, it leaves urethane in a pure state. If a solution of these crystals is boiled with NaOH, ammonia is evolved, showing the presence of nitrogen. If this alkaline solution is treated with an acid CO_2 is evolved.

ANALYSIS OF SUBSTANCE DRIED IN AN EXSICCATOR OVER SULPHURIC ACID.

0.1047 gram of substance gave 0.1537 of CO_2 and 0.0736 H_2O ,
Which equals.....40.00 per cent. C.
and.....7.83 " " H.
Nitrogen, by Kjeldahl's process.....14.90 " " N.
Urethane ($\text{C}_2\text{H}_5\text{NO}_2$).

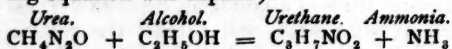
Requires	Found.
C = 40.44 per cent.;	C = 40.00 per cent.
H = 7.86 " "	H = 7.83 " "
N = 15.70 " "	N = 14.90 " "

If a little of this substance was dissolved in distilled water, and the solution treated with a solution of carbonate of soda and a few scales of iodine and then heated, the smell of iodoform was produced. This solution, upon cooling, deposited crystals of iodoform. If part of the crystals are treated with solution of ammonia, heated in a closed tube, neutralized with dilute sulphuric acid, and then submitted to distillate gave a distinct reaction for alcohol, with the iodoform test and chromic acid reaction, which is explained by the following equation:



conclusively prove that this substance is identical with urethane.

As urethane is formed by the action of alcohol upon urea when heated (as the following equation will explain):



Dr. R. thought it best to treat normal urine the same way that he had treated the albuminous urine, but not a trace of urethane was formed; however, if the alcoholic extract of normal urine was evaporated at a high temperature, urethane was always formed.

Urethane is a powerful narcotic, and Dr. R. advances theory that to this substance the so-called "uræmic poisoning" in Bright's disease is due.—*American Pract. and News.*

NEWS AND MISCELLANY.

THE FIVE YEARS' CURRICULUM.

The difficulties which will occur to everyone as to the best means of utilizing the extended period of education of the medical student are strikingly shown in the report of the Committee of Management of the Examining Board in England which has just been issued, and which will come on for discussion at the next meetings of the respective authorities of the two colleges. The committees are generally agreed on the subjects of the curriculum, but differ as to the number of examinations which should be held during the five years of study. The six members have three different views as to this point, and so three schemes will be submitted to the two colleges for their decision. Under the first scheme, recommended by the medical representatives of the Committee of Management, there would be three examinations, as at present: the first, after six months' attendance at a medical school, would embrace chemistry and physics, pharmacy, elementary human anatomy and elementary biology; the second, at the expiration of the second winter session, would include anatomy and physiology; the final, after the expiration of three winter and three summer sessions from the date of the candidate passing the second examination, would deal with medicine, surgery, and midwifery. During this last period the student must have received clinical instruction in fevers and small-pox. The scheme practically alters but very little the present arrangement, except that elementary biology is added to the first examination, that courses of lectures on public health and therapeutics must also be attended, and that a special paper on

forensic medicine, public health, and general therapeutics forms part of the examination. The second scheme, presented by two of the surgical representatives, is similar, so far as the first and second examinations are concerned, but the third examination is to be passed at the expiration of two years from the date of passing the second examination, and consists of medicine, surgery, and midwifery, as at present; but the latter subject may be taken at the fourth examination if the candidate elect to do so. Under this scheme the final year is to be devoted simply to an extra year's attendance at a Hospital (to include attendance at a fever Hospital) and a fourth or final examination in clinical medicine and surgery must then be passed. In the third scheme drawn up by the remaining surgical members of the committee the student is required to pass a series of annual examinations, the first in chemistry and physics, elementary human anatomy, and elementary biology; the second in anatomy, physiology, and elementary pathological anatomy; the third in anatomy, including histology, physiology, pathological anatomy, pharmacy, and elementary knowledge of drugs; the fourth in the principles of medicine and surgery and in pathology; whilst the fifth, or final, embraces the practice of medicine, the practice of surgery, the practice of midwifery and diseases of women, and the elements of forensic medicine and of public health. Doubtless there will be many differences of opinion as to the relative value of the schemes, but at present we would only point out that they all agree in introducing into the curriculum the subject of elementary biology; that ophthalmology, diseases of children, and mental diseases are unmentioned; that there is no provision made for spending the fifth year with a practitioner as a pupil, but the extra year practically becomes merely an additional year of ordinary Hospital study and hospital work, except that a certain unspecified time is to be given to fevers. We question if these arrangements are such as were anticipated by the General Medical Council when they passed the resolution insisting on this fifth year of medical education.—*Lancet.*

A TEN YEAR'S CURRICULUM.

The course of medical study at the Buddhists' Lama University, in Thibet, is ten years. The first four years are devoted to language and theology, the eighth year to astrology, and physiology succeeds only in the last two years.—*Ex.*

HARVARD MEDICAL SCHOOL FELLOW-SHIPS.

Three scholarships of \$5,000 each have been established through the gift of William S. Bullard.

THE exhibition of bacteriological apparatus at the coming International Congress of Hygiene, promises to be exceptionably fine.

A HOSPITAL FOR INFECTIOUS DISEASES IN TURIN.

The King of Italy gave 160,000 lire (\$32,000) on his last birthday to the city of Turin to assist in the erection of a hospital for contagious diseases.

DR. JAMES N. MARTIN has been appointed Professor of Obstetrics and Diseases of Women at the University of Michigan. He filled the chair since Prof. Dunster's death.

CRYSTALLIZED CHLOROFORM.—The Swiss physicist, Raoul Pictet, has discovered a method of preparing crystallized chloroform for commercial use. Kept in this form it cannot undergo any changes or contain any impurities.

PYOKTANIN STAINS REMOVABLE.

The blue stains on the hands, etc., from Pyoktanin, are readily removable by lathering with common soap (rubbing-in well,) and then washing (or, if need be, brushing) off with alcohol, or with any strong alcoholic liquor.—*Mercks Bulletin.*

MEDICAL DIPLOMAS IN KENTUCKY.

Resolved that the Secretary be instructed to place upon the list of medical colleges whose diplomas are to be certified and endorsed for registration under the laws of this State, only such colleges as shall, after the session of 1891-2, exact of matriculates and graduates a minimum of requirements not less than those required by the American Medical College Association.

THE ASSOCIATION OF GERMAN ALIENISTS

The Association of German Alienists will meet this year at Weimar, on September 18th and 19th. The following questions among others will be discussed: Responsibility and Criminality, Drunkenness in Re-

lation to Responsibility, Prophylaxis of Tuberculosis in Lunatic Asylums, the Present Condition of the Aphasia Questions, Therapeutic Employment of Hypnosis in Lunatic Asylums, Care of Epileptics.

KOCH INSTITUTE IN BERLIN.

The clinical section of the new Institute will be completed within a few weeks. There are seven parlors, having accommodations for 108 patients, and two parlors for physicians and attendants. Prof. Ludwig Brieger, will probably be at the head of the clinical department, and Dr. Richard Pfleger will have charge of the scientific department. Koch, it is said, will receive a salary of 20,000 marks (\$5,000,) and Drs. Brieger and Pfleger each 6,000 marks (\$1,500.)

SOCIETY MEETINGS.

The American Association of Obstetricians and Gynecologists will hold its fourth annual meeting, at the New York Academy of Medicine, 17 West Forty-third street, in the City of New York, Thursday, Friday, and Saturday, September 17, 18 and 19, 1891, under the presidency of Dr. Adam H. Wright, of Toronto. All physicians interested in the discussion of subjects pertaining to Abdominal Surgery, Obstetrics, and Gynecology are invited to attend without further formal notice. By order of the Executive Council.

WILLIAM WARREN POTTER, M. D.,
Secretary.

COMPARATIVE COST OF MEDICAL EDUCATION IN ENGLAND AND AMERICA.

According to the estimate of the Secretary of the Illinois Board of Health, the average fees for the eleven London schools are, exclusive of the examination fees, £118, 5s.; for the provincial schools, £98. In addition each student has to pay from 10s. to £3 matriculation to one of the degree-granting bodies; from £1 to £15 for 1st examination; from £1 to £10 for the 2d; from £2 to £15 for the first degree or qualification examination. In some of the colleges in the United States all the fees do not amount to \$300, and in at least one the whole course of study and the diploma can be had for \$138.

The first annual meeting of the U. S. Medical Practitioners' Protective Alliance was held at Baltimore, June 11th and 12th. The society was incorporated under the laws

of Maryland. Officers for the ensuing year were elected, and such other business transacted as was necessary to establish the Alliance on a basis of permanence. As usual in meetings for organization, comparatively little work could be done outside the regular routine in such cases. Addresses were delivered by the officers, and several papers on alliance work in general were read and discussed. The proceedings will be published in a few weeks.

THE BRITISH MEDICAL ASSOCIATION.

The fifty-ninth annual meeting of the Association will be held at Bournemouth on July 28th and three following days. The President-elect is Dr. J. R. Thomson, consulting physician to the Royal Victoria Hospital, Bournemouth. Addresses in Medicine, in Surgery, and in Public Medicine will be given by Dr. Lauder Brunton, by Dr. John Chiene, and by Dr. E. C. Seaton respectively. The scientific business will be conducted in nine sections, presided over by distinguished members of the profession. The exhibits at the animal museum will be arranged in five sections. At the dinner of the Metropolitan Counties Branch of the Association the treasurer of the Association, Mr. Butlin, expressed the hope that the annual meeting would be held in London in the year 1894.

CANADIAN MEDICAL CERTIFICATES.

The College of Physicians and Surgeons of the Province of Quebec has, with the earnest coöperation of the universities, been endeavoring to get its certificates recognized in Great Britain on the principle of reciprocity. The terms of the Act of 1886 require, however, that before foreign or colonial diplomas can be recognized in England they must be recognized in the country in which they are obtained. Qualifications gained in Quebec are only recognized in the province of Quebec. Canada herself in other provinces does not recognize the certificates of the province of Quebec. In great questions this partial application of legislation provincialises and belittles; and it will have to be modified if countries with strong central Governments are to recognize those where local restrictions prevail.

THE AMERICAN SOCIETY OF MICROSCOPISTS.

This association, now in the thirteenth

year of its existence will hold its fourteenth annual meeting in Washington, D. C., August 10, and continue in session five days. Its roll of active members contains about three hundred and fifty names, embracing very nearly every person in the United States who is at all prominent as a microscopist. Its membership consists of two distinct classes, viz.: professional men and students of the natural sciences, who use the microscope in their daily avocations as an instrument of research, diagnosis, or precision; and amateurs, or those who find pleasure and profit in the revelations of the instrument. Many of the latter class, from having chosen special lines of study and investigation, have acquired high reputations in their respective departments of microscopical research. In its earlier years this class predominated in the membership of the society, but at present the professional element is largely in excess.

The qualifications for membership are very simple. The applicant must be a respectable person socially, and interested in the use of the microscope.

A MEDICAL TEMPERANCE CONGRESS.

The managers of the National Prohibition Park, of Staten Island, invite representative medical men from all localities in the United States and the Dominion of Canada to meet in conference on the 15th and 16th of July in the great Auditorium Building of the Park. The chief object of the meeting is to be the comparison of views on the relationship of physiology and alcohol. Among the questions to be discussed will be the following: "What are the Hereditary Effects of Drunkenness?" "Are there any Hereditary Effects that Follow Moderate Drinking?" "To what Diseases are Inebriates More Especially Exposed?" "Is Alcohol a Poison?" "Is Alcohol in any Sense a Food?" "What are the Proper Uses of Alcohol as a Medicine?" "Is there Danger of Producing the Drink Habit from the Prescribing of Alcoholic Medicines?" "How Large a Percentage of Deaths May be Attributed, Directly or Indirectly, to the Use of Strong Drink?" "Should Alcoholic Liquors Ever be Used Except Under the Direction of a Medical Adviser?" It is announced that, at this Conference, all views will be given an impartial hearing, and no restraint will be placed upon the discussion save that of the time limit.

HOW TO LOOSEN GLASS STOPPERS.

The *Pottery & Glassware Rep.* states that some one of the following methods is certain to prove effective:

1. Hold the bottle or decanter firmly in the hand or between the knees, and gently tap the stopper on alternate sides, using for the purpose a small piece of wood, and directing the strokes upward.

2. Plunge the neck of the vessel in hot water, taking care that the water is not hot enough to split the glass. If the stopper is still fixed, use the first method.

3. Pass a piece of lint around the neck of the bottle, which must be held fast while two persons draw the lint backwards and forwards.

4. Warm the neck of the vessel before the fire and when it is nearly hot the stopper can be removed.

5. Put a few drops of oil around the stopper where it enters the glass vessel which may then be warmed before the fire. Then apply process No. 1. If the stopper still continues immovable, repeat the above process until it gives way, which it is almost sure to do in the end.

6. Take a steel pin or needle and run it round the top of the stopper in the angle formed by it and the bottle. Then hold the vessel in your left hand and give it a steady twist toward you with the right, and it will very soon be effectual. If this does not succeed, try process No. 5 which will be facilitated by it.

FOREIGN BODIES SWALLOWED BY A STOWAWAY.

On Thursday, May 21st, the body of an Arab, found dead on one of the ships in the Albert Dock, was taken to the Seamen's Hospital, name unknown. A necropsy was ordered by the coroner, and made by Dr. F. Croucher, house surgeon to the branch hospital. There were no signs of disease in the brain or the chest, except a few old adhesions in the left pleural cavity. The gall-bladder was very distended and full. Three small ulcers existed on the anterior coat of the stomach. Several patches of inflammation were found in the small intestine. In the cæcum were found twenty trousers buttons, three cog-wheels (apparently out of a watch, two of them 1 in. in diameter—these were doubled), one 2 in. steel screw bent double and one 1 in. screw, six pieces of a lock (the biggest piece was 1½ in. long and ½ in. broad), a circular

piece of brass (1½ in. in diameter folded into four), several pieces of iron wire (four were 1½ in. in length), brass, and lead, and two key tallies on a ring, one inch in length. In the ascending colon, about five inches from the cæcum, were found a piece of steel wire one-eighth of an inch in diameter, and three inches and half in length, bent double, and one small cog-wheel. The weight of these bodies together amounted almost exactly to half a pound. The body was much emaciated; no subcutaneous fat was present in chest or abdominal walls, or any fat round the kidneys. The deceased was quite unknown; no particulars could be discovered by the police employed to obtain evidence for the purpose of the inquest. There was no perforation of intestines, or any sign of disease in the colon.—*Lancet.*

A DUBLIN DOCTOR'S DOGGERELS.

This is a little book of rhymes, originally printed for private circulation, and now, as the author says "saved from the waste paper basket." It would have been a great pity if they had been consigned to that ignominious receptacle for they are irresistibly funny and marked by much cleverness, both of idea and of expression. The medical poems, or rather we should call them skits, are especially amusing. Here is a specimen:—

Should you suffer from lumbago,
Live on nothing else but sago,
Rub the lower part of spine
With the strongest turpentine,
Try the treatment used by quacks,
Drop on melting sealing wax.
If there still is no relief
Try a six-inch mustard leaf,
Take a needle and a syringe
Inject ether every twinge,
If there's no relief from pain
Try a Pulvermacher's chain.
Then rub smartly with sand paper,
It will make you dance and caper,
Then, while resting from your toil,
Smear the part with "Jacob's Oil."
If all fail, try belladonna,
It will cure you, 'pon my honor.

Here is another:—

Doctors wonder, and well they may,
How the profession can possibly pay,
Hundreds still will crowd the ranks,
Giving advice without fees or thanks.
Too many Hospitals, far too many,
Giving their help without charging a penny,

Hundreds who could afford a fee,
Get at a Dispensary treatment free.
The profession allows it, what's the use
Of alluding at all to such an abuse?
The struggling practitioners doing their
duty,
While quacks and bone-setters live on the
booty.

It is clear that a humorist and rhymers of
the first water has been lost to the laughter-
loving public in the Dublin doctor.—*Med-
ical Press.*

THE INTER-CONTINENTAL AMERICAN MEDICAL CONGRESS.

OFFICE OF THE PERMANENT SECRETARY
OF THE AMERICAN MEDICAL ASSOCIATION.

Philadelphia, June 4th, 1891.

*To the Medical Profession of the Western
Hemisphere:*

At the meeting of the American Medical
Association, held at Washington, May 5th,
1891, Dr. Charles A. L. Reed, of Cincinnati,
introduced the following:

Resolved, That the American Medical Association hereby extends a cordial invitation to the Medical Profession of the Western Hemisphere, to assemble in the United States in an Inter-Continental American Medical Congress.

Resolved, That the Committee on Nominations be and is hereby instructed to nominate one member for each State and Territory, and one each from the Army, Navy, and Marine Hospital Service, who shall constitute a committee, which is hereby instructed to effect a permanent organization of the proposed Inter-Continental American Medical Congress, and to determine the time and place at which the same shall be held.

The resolutions were seconded by Dr. Wm. H. Pancost and others, and unanimously adopted.

Pursuant to the foregoing the following Committee was nominated and elected:

Alabama—R. F. Saunders.
Arizona—Henry A. Hughes.
Arkansas—Ed. Bentley.
California—W. R. Cluness.
Colorado—Wm. A. Campbell.
Connecticut—C. A. Lindsley.
Delaware—C. H. Richards.
District of Columbia—D. W. Prentiss.
Florida—C. R. Oglesby.
Georgia—J. McFadden Gasten.
Idaho—Geo. P. Haley.
Illinois—N. S. Davis.
Indiana—A. M. Owen.
Iowa—B. H. Criley.
Kansas—J. E. Minney.
Kentucky—J. N. McCormack.
Louisiana—Stanford E. Chaille.
Maine—Hampton E. Hill,

Maryland—Geo. H. Rohe.
Massachusetts—Augustus P. Clarke.
Michigan—C. Henri Leonard.
Minnesota—P. H. Millard.
Mississippi—W. F. Kendell.
Missouri—I. N. Love.
Montana—Thos. J. Murray.
Nebraska—R. C. Moore.
Nevada—P. J. Aiken.
New Hampshire—Irving J. Watson.
New Jersey—E. J. Marsh.
New Mexico—C. E. Winslow.
New York—John Cronyn.
North Carolina—H. Longstreet Taylor.
North Dakota—E. M. Darrow.
Ohio—Charles A. L. Reed.
Oregon—Wm. Boys.
Pennsylvania—Wm. Pepper.
Rhode Island—Geo. L. Collins.
South Carolina—R. A. Kinloch.
South Dakota—J. W. Freeman.
Tennessee—J. R. Buist.
Texas—J. W. Carhart.
Utah—F. S. Bascom.
Vermont—H. H. Holton.
Virginia—J. S. Wellford.
Washington—J. M. Morgan.
West Virginia—J. H. Brownfield.
Wisconsin—J. T. Reeve.
Wyoming—J. H. Finrock.
U. S. A.—
U. S. N.—A. L. Gihon.
U. S. M. H. S.—J. B. Hamilton.

WM. T. BRIGGS, M. D., *President.*
WM. B. ATKINSON, M. D., *Per. Sec.*

THE INTER-CONTINENTAL AMERICAN MEDICAL CONGRESS.

OFFICE OF THE CHAIRMAN OF THE COMMITTEE ON PERMANENT ORGANIZATION.

Cincinnati, June 6th, 1891.

The Committee appointed by the American Medical Association to effect a permanent organization of the Inter-Continental American Medical Congress, met at "The Arlington," Washington, May 7, 1891. The following officers were elected: Charles A. L. Reed, M. D., Cincinnati, O., Chairman; J. W. Carhart, M. D., Lampasas, Texas, Secretary; I. N. Love, M. D., St. Louis, Mo., Treasurer.

On motion, the officers were appointed a special Committee to draft a Constitution, and report the same at an adjourned meeting of the general Committee, to be held at St. Louis, Mo., Wednesday, October 14, 1891, when the time and place of meeting of the Congress will be decided, and permanent officers be elected.

CHARLES A. L. REED, M. D., *Chairman.*
J. W. CARHART, M. D., *Secretary.*

PROFESSOR ANGERER, of Munich, has been appointed Professor of Surgery in the University of that City, to succeed Nussbaum.